THE PERCEPTIONS OF ADOLESCENTS ON THE USE OF HIV YOUTH FRIENDLY CENTRE IN MASERU, LESOTHO

By

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DEDICATION

I would like to dedicate this Master's dissertation to my God, who gave me the necessary power, strength and energy. There is no doubt in my mind that without His blessings, I could not have completed this project.

DECLARATION

I declare that **THE PERCEPTIONS OF ADOLESCENTS ON THE USE OF HIV YOUTH-FRIENDLY CENTRE AT MASERU, LESOTHO** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references. I further declare that I submitted the dissertation to originality checking software and that it falls within the accepted requirements for originality.

Thabiso Alphonce Lekhotsa **15 September 2019**

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ABSTRACT

This qualitative exploratory study explored adolescents' perceptions of the HIV youth friendly centre at a hospital in Lesotho in order to improve adolescent-friendly health care services in Lesotho. Data was obtained through interviewing nine purposively selected adolescents aged 18–19 years who accessed health care services at the centre, and was analysed using an adapted version of Colaizzi's seven-step thematic analysis. Six themes emerged from this study: attributes experienced during adolescents' visits to health care facilities, adolescents' perceptions of the health care facility, waiting times, facts related to HIV pre-test counselling, description of services available for adolescents' health, and challenges faced by adolescents in relation to their HIV positive status. The adolescents explained the factors that encouraged them to be tested, and to commit to HIV management and treatment. The findings showed that it is important to reserve a dedicated space for adolescents, to provide comprehensive health services at one site, to ensure adolescents' privacy and confidentiality, to indicate patient flow clearly, to indicate the service offering clearly, to offer flexible operating hours and days, to involve youth in the service provision, to keep queues short, and to establish peer support groups.

KEY CONCEPTS:

Adolescents, youth-friendly services, HIV testing, HIV treatment, health care facilities

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LIST OF ABBREVIATIONS

AGYW	Adolescent Girls and Young Women
AIDS	Acquired Immune Deficiency Syndrome
ALHIV	Adolescents Living with HIV
ART	Antiretroviral Treatment
NAFCI	National Adolescent-Friendly Clinic Initiative
YFS	Youth-Friendly Services
HIV	Human Immunodeficiency Virus
HTS	HIV-testing Services
LDHS	Lesotho Demographic Health Survey
MCH	Maternal and Child-Health
mHealth	Mobile Health
PMTCT	Prevention of Mother-to-Child Transmission
PrEP	Pre-Exposure Prophylaxis
STI	Sexually Transmitted Infection
UNAIDS	Joint United Nations Programme on HIV and AIDS
VCT	Voluntary Counselling and Testing
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization

CHAPTER ONE

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

The Kingdom of Lesotho is one of the nations in sub-Saharan Africa that has been most affected by the global HIV (human immunodeficiency virus) pandemic. Lesotho has a population of about 2.1 million people, of which an estimated 314,000 are living with HIV, including 13,000 children under the age of 15 and 498,000 adolescents. The World Health Organization (WHO) defines adolescents as young people aged 10–19 (WHO, 2014). Adolescents make up about 25% of the population, and in 2013 an estimated 2,800 new HIV infections in Lesotho occurred among adolescents (Ministry of Health, Lesotho 2015:4). In 2014, a WHO report on the second decade of life, 10–19 years, identified significant health needs and gaps within countries' current health care systems, and concluded that there is a need to respond to these illnesses. Most notably, the WHO (2014:25) report identified HIV, as the number one cause of death in adolescents in Africa (WHO 2014:3). As part of its response to the HIV pandemic, Lesotho established three youth-friendly centres in 1999, and the number had expanded to 23 by 2006. These are facilities that offer health care services that do not discriminate or intimidate, and that are accessible, acceptable, affordable, and appropriate for adolescents and young people (WHO 2012:7).

Adolescents, or young people aged between 18 and 19 years, is a population group in the transitional period between childhood and adulthood. They undergo major physical, emotional, and social changes, which has a significant impact on their health and development (WHO 2014:36). While some of them successfully go through this transition into adulthood, others fail to overcome the challenges of this important stage and eventually miss the opportunity to realise their full potential in life (Mujugira, Celum, Coombs, Campbell, Ndase, Ronald, Were, Bukusi, Mugo, Kiarie & Baeten, 2015:189).

Adolescents account for a quarter of the population of Lesotho (Ministry of Health [Lesotho] & ICF International 2016:3), and, as elsewhere, they face many challenges, including high unemployment and the associated risky behaviours, such as substance

abuse (Thupayagale-Tshweneagae, Mzolo & Siband, 2017: 69). They have limited knowledge regarding their health that would empower them to make healthy choices (Tan, Cho, Fairley, Chen, Bradshaw & Read, 2016:79). Inadequate information may lead to indulgence in risky sexual behaviours, with serious consequences for teen pregnancy and sexually transmitted diseases, including HIV and AIDS. They often have suboptimal health outcomes, due to poor health knowledge and a lack of adolescent-friendly options in the health services. Older adolescents and young adults have high rates of new HIV infections, especially among adolescent girls and young women (AGYW). This is due to the low rate of HIV testing among adolescents and young people, despite a median age of first sexual intercourse of 18 years. There are also a significant number of undiagnosed perinatal-infected adolescents living with HIV. After an adolescent is identified as having HIV, the rates of linkage to care and antiretroviral treatment (ART), retention, and viral suppression are lower than for those of other age groups (Sebola 2014:56).

1.2 BACKGROUND TO THE RESEARCH

AIDS is a leading cause of death and morbidity among Basotho adolescents, and in 2013 an estimated 1,200 adolescents died of AIDS in Lesotho. The highest HIV prevalence rates are in urban Maseru (28%), where the Public Hospital is located, and there are lower HIV prevalence rates in the more rural Mohale's Hoek (20%). While there has been significant progress in the fight against AIDS globally, substantial work needs to be done to reach adolescents who are affected by and infected with HIV.

AIDS has become the leading cause of death among adolescents in sub-Saharan Africa, and the second leading cause of death for adolescents globally. Ensuring that young people visit clinics and have access to reliable health care advice is a top priority for the Lesotho government. The Ministry of Health has established adolescent health care corners in hospitals to address the unique barriers of young people due to their stage in life and associated special needs, perceptions, and abilities. Youth-friendly services (YFS) are able to effectively attract young people, meet their needs comfortably and responsively, and succeed in retaining young clients for continuing care (Ministry of Health, Lesotho 2015:4).

The Public Hospital, a high-volume health care site in Maseru, Lesotho, established its adolescent health care corner in October 2016. Since then, it has played an important role in testing adolescents for HIV, initiating their ART, retaining them for ongoing treatment, and ensuring that they remain virally suppressed. This is one of the best performing adolescent health care corner in Lesotho, and sees large numbers of adolescents accessing HIV services; however, it still does not meet the targets established for testing adolescents for HIV, initiating their ART, and retaining them for treatment. The researcher became interested in what prompted adolescents to use or avoid the adolescent health care centre, and it became clear that research needed to be conducted on adolescents' perceptions of the use of the youth-friendly adolescent HIV services at the youth clinic.

1.3 THE RESEARCH PROBLEM

Appropriate health care interventions for adolescents and young people are key to ending the HIV epidemic in Lesotho, and also provide an opportunity to address the existing sexual and reproductive health needs of a generation. The youth are an important group, but they are often underserved in clinics and are given insufficient priority as a result of barriers unique to young people at their stage in life, associated with their special needs, perceptions, and abilities. The period of adolescence is associated with significant sexual, reproductive, cognitive, and psychological changes. However, one of the biggest complaints from adolescents is about the treatment they receive at health centres. Many say that they do not feel that they are free to ask questions about their sexual health, and that they do not receive a warm welcome from the nurses; some say that they get judgemental responses to questions on sexual health, or are told to go home; and some avoid health centres out of a sense of embarrassment when the staff members at the centre are people known to them or related to them, particularly in smaller, more remote areas. Health care providers are often overworked, due to their long hours and the wide range of issues that they respond to, and often do not have the mental and emotional resources to be adequately sensitive to young people's needs. In addition, they may not be familiar or experienced enough with to what adolescents need in terms of good quality service in a health care facility (Ministry of Health, Lesotho 2015:4). In the context of the Public Hospital in Maseru, not enough is understood about the perceptions of adolescents

on the use of the Public youth-friendly health care centre, particularly in relation to HIV health care services.

1.4 DEFINITION OF THE KEY CONCEPTS

- **Adolescents**: The WHO defines adolescents as young people between 10 and 19 years old (WHO 2015:31).
- **HIV**: HIV (human immunodeficiency virus) is a virus that attacks the immune system, the body's natural defence system (UNAIDS 2016:15).
- **Perception:** A perception is a particular way of thinking about something, or a point of view (Oxford Advanced Learner's Dictionary 2016:1132).
- **Youth-friendly service:** These are health services that do not discriminate or intimidate, and they are accessible, acceptable, affordable, and appropriate for adolescents and young people (WHO 2012:7).

1.5 RESEARCH PURPOSE

The purpose of this study was to investigate the perceptions of adolescents on the use of the HIV youth-friendly centre in a hospital in Lesotho.

1.6 OBJECTIVES OF THE STUDY

According to Brink, van der Walt & van Rensburg (2012:85), a research objective is based on the researcher's understanding, and it can be described as a summary of what is to be achieved by the study. In order to investigate the perceptions of adolescents on the use of the HIV youth-friendly centre in a hospital in Lesotho, the following objectives were formulated:

- To explore and describe the perceptions of adolescents on the use of youth friendly services.
- To identify the best practices that could be recommended to the health care authorities, in order to scale up youth-friendly services.

1.7 RESEARCH QUESTIONS

Polit and Beck (2012:75) explained that a research question relates directly to the selected research topic. It is linked logically and conceptually by using the same terms as those used in the statement of the research purpose, and in the research objectives. The research questions stipulate what it is about the topic that the researcher wants to find out. For this study, the following two research questions were formulated:

1. What are the perceptions of adolescents on the use of the youth-friendly services?
2. What recommendations could be made to health care authorities regarding the use of the youth-friendly services by the adolescents?

1.8 THE RESEARCH METHODOLOGY

According to Polit and Beck (2012:11), research methods are techniques that the researchers use to structure a study, and to gather and analyse the relevant information for the research question. The research methodology focuses on the research process, and the types of tools and procedures to be used in the study. The following sections briefly outline the research design, the research methods (population and sampling, data collection, and data analysis), the trustworthiness of the study, and the ethical considerations that were taken into account in conducting the research.

1.8.1 The research design

For this qualitative study, an exploratory research design was utilised. An exploratory design is used when a researcher examines a new area of interest, or when the subject of the study itself is relatively new. Exploratory research is conducted on a research problem when there are few or no earlier studies to refer to or to rely on to predict an outcome.

1.8.2 The research methods

1.8.2.1 Population and sample selection

The study population is the entire group of persons or subjects that is of interest to the researcher. According to McMillan and Schumacher (2013:169), a population is a group of elements or cases — whether individuals, objects or events — that conform to specific criteria, and to which the researcher intends to generalise the results of the research. The study was conducted at the Public Hospital adolescent health care centre in Maseru, and adolescents aged 18–19 years who accessed HIV services comprised the population of the study. The population for this study was therefore defined as follows: adolescents aged 18–19 years accessing HIV services at the adolescent health care centre of Public Hospital in Maseru, Lesotho.

1.8.2.2 Sample and sampling

After the population had been identified, the sampling was performed. According to Polit and Beck (2012:743), sampling is the process of selecting a portion of the population to represent the entire population. Sampling refers to the researcher's process of selecting the sample from a population, in order to obtain information regarding a phenomenon, in a way that represents the population of interest (Brink et al. 2012:130). Purposive sampling was used to select the participants. Purpose sampling is a non-probability sampling method, in terms of which the researcher selects the participants based on his or her personal judgement about which participants would be the most informative (Joubert 2014:741). This means that not all the people in the population have an equal chance, or the same probability, of being included in the sample; and, for each one of them, the probability of inclusion is unknown. Purposive sampling is used when the researcher wants to purposefully select a particular sample.

1.8.2.3 The data collection

Data collection is the precise, systematic gathering of information relevant to the research purpose or to the specific objectives, or the hypothesis of the study (Brink et al. 2012:132; Grove, Burns & Gray 2013:52). A grand tour question was used to collect the data, where a broad question was asked in a semi-structured interview, in order to gain a general overview of a phenomenon, on the basis of which more focused questions were subsequently asked (Polit & Beck 2012:729). The researcher asked the questions and probed the responses of the participants in line with the study's objectives. The data was

collected using a voice recorder, which the researcher sought the participants' permission to use. The researcher interviewed the participants until data saturation was reached.

1.8.2.4 Data analysis

Grove et al. (2013:535) describe data analysis as a technique used to reduce, organise, and give meaning to information. The process of data analysis involves making sense of textual and image-based data (Botma, Greeff, Mulaudzi & Wright 2014:220). Data analysis was performed concurrently with the data collection, and this study performed a thematic analysis of the voice recordings and the field notes taken during the data collection. The voice recordings were transcribed into textual data, and this data was categorised into themes using an adapted form of Colaizzi's (1978) seven steps of analysis (as cited in Bazeley 2013:65). These steps are described in section 3.2.5.

1.8.3 Trustworthiness

Researchers should try to achieve trustworthiness in qualitative research, also known as rigour, in order to confirm that the findings are of use to other researchers (Noble & Smith 2015:34). The following measures of trustworthiness, as suggested by Polit and Beck (2012), were applied to ensure the rigour of this research: credibility, dependability, confirmability, transferability, and authenticity. The application of these is discussed in detail in section 3.3.

1.8.4 Ethical considerations

According to Brink et al. (2012:32), a researcher is responsible for conducting his or her research in an ethical manner — from the conceptualisation and the planning phases, through to the implementation phase, and then to the dissemination phase. In this study, five principles for ethical research were adhered to: informed consent, privacy and confidentiality, autonomy, beneficence, and justice. These are discussed in detail in section 3.4.

1.9 SIGNIFICANCE

The findings of this study are relevant to health care providers, adolescents, and policy makers. The findings could be used by health care providers to understand the issues that influence how adolescents access and utilise health care services. They therefore assist in addressing the needs of adolescents for adolescent-friendly health care services. Policy makers could use these findings to assist in formulating best practices for adolescent health care services, and to ensure that these practices are standardised across the country. They could develop policies to ensure that adolescent-friendly health care services are implemented at all health centres to address whatever challenges adolescents may face.

1.10 SCOPE AND LIMITATIONS

This was a qualitative study that was limited to the perceptions of adolescents in Maseru aged 18–19 years, and included only nine participants. The findings cannot therefore be generalised. Studies conducted in other contexts, and with other age groups, may produce quite different perceptions and findings.

1.11 CONCLUSION

This chapter has provided an introduction and general orientation to the research report. It has focused on formulating and framing the research problem by outlining the background to the research, defining key concepts, and presenting the research purpose, the objectives of the study, and the research questions. The research methodology used in the study was presented by describing the qualitative, exploratory research design, the population and the purposive sampling, the semi-structured interviews conducted to generate data, and the thematic analysis used to analyse the data, based on Colaizzi's (1978) seven-step process as cited in Bazeley 2020:63. The measures that were taken to strengthen the trustworthiness of the study, and ethical considerations that the research took into account, were also discussed. Finally, the significance of the study and its limitations were mentioned. The following chapter will provide a review of literature on the importance of adolescent-friendly health services in the context of the HIV pandemic.

CHAPTER 2

THE LITERATURE REVIEW

2.1 INTRODUCTION

A literature review seeks to identify a relevant theoretical and conceptual framework for defining the research problem, to lay the foundation for the study, to inspire new ideas, and to determine any gaps or inconsistencies in the body of research (Polit & Beck 2012:87). For this study, the literature review focuses on the importance of adolescent friendly health care services, in the particular context of the HIV pandemic. In discussing the relevant existing literature, the following areas are highlighted: adolescents and HIV; HIV services and adolescents; adolescent-friendly health services; best practice for HIV service to adolescents; and the challenges of HIV testing for adolescents.

2.2 ADOLESCENTS AND HIV

Reif, Bertrand, Benedict, Lamb, Rouzier, Verdier, Johnson, Pape, Fitzgerald, Kuhn and McNairy (2016:1) state that AIDS is the leading cause of death in adolescents and the youth in sub-Saharan Africa and the Caribbean. Globally, between 2005 and 2012, AIDSrelated deaths increased by 50% among adolescents compared with all other age groups, which together experienced a 32% decrease.

Approximately 2.1 million adolescents aged 10–19 are living with HIV globally. 900,000 new HIV infections occur annually among adolescents, representing 40% of all new infections in resource-limited settings. A lot of effort to prevent HIV transmission among the adult population has shown substantial success; however, while youths between the ages of 15 and 24 face considerable challenges.

Estimates show that one third of all new HIV cases worldwide now occur among people aged 15–24, that the increased availability of antiretroviral therapy (ART) has dramatically extended lifespans, and that many children who were born with HIV are now beginning to move into adolescence and adulthood. Despite broad improvements in long-term HIV

related health outcomes, globally the HIV-related mortality among adolescents has tripled since 2000, and it is now the second leading cause of death among youth aged 10–19 (Reif et al. 2016:1).

Reif et al. (2016:2) further stated that the needs and desires of adolescents and young people are frequently neglected. Many have outgrown paediatric services, but they do not yet feel comfortable with the existing adult services. Even though ART accessibility has improved, poor adherence remains common among the youth, which may impede viral suppression, lead to treatment failure, and undermine the effectiveness of ART, not only for improving the health of the recipient, but also for preventing further HIV transmission.

The poor availability of reliable and trustworthy sources of information for adolescents has led to their lack of comprehensive understanding of HIV transmission. There is often a lack of strategies available to adolescents for safely navigating their nascent romantic and sexual relationships. Consequently, many engage in behaviours that accelerate sexually transmitted infections (STI) and HIV transmission.

2.3 HIV SERVICES AND ADOLESCENTS

Enrolling and retaining adolescents and youth in health services for HIV care and treatment remains a significant challenge. Targeted services tailored to the specific needs of adolescents and the youth — including dedicated adolescent-care clinics, peer-support groups, and sexual and reproductive services — have been cited as a way of improving care outcomes.

Evaluations of the impact of these services, particularly in resource-limited settings, where most HIV-infected young people live, have been very limited. Offering a basic set of youth-friendly services (YFS), including dedicated clinics and support groups targeted at adolescents and youth, may not be adequate to surmount the retention barriers faced by young people living with HIV/AIDS.

Other factors may also contribute to the retention of this group. A recent study, conducted in Nyanza, Kenya, found that many youths reported disengaging from care as a result of

the stigma and the fear of disclosure to parents, teachers, and clinicians (Teasdale, Alwar, Chege, Fayorsey, Hawken, & Abrams 2016:e56).

HIV-testing services (HTS) are a critical entry point to care. However, despite the high level of knowledge on where to access HTS, HTS rates among adolescents remain low. There are several barriers to testing for adolescents, which can be characterised as personal, community, or structural barriers. These barriers include the pervasive stigma of HIV; inconvenient clinic hours or locations; lack of transportation; the negative attitudes of health care workers; the fear of lack of confidentiality, especially when it comes to sensitive health issues such as contraception and pregnancy, and STIs; and the fear of forced disclosure of health conditions, especially HIV status. To overcome all these barriers, Namibia has developed youth-friendly testing sites, following the WHO recommendation for adolescent-friendly services. Currently, 20% of all HTS sites in Namibia, which are located primarily at health centres and clinics, are characterised as being adolescent-friendly. However, data for determining the impact of these sites on testing and services is not available (Republic of Namibia Ministry of Health and Social Services 2012:3).

According to Lung, Zieman, Banura, Okal, Elang, Ampwera, Caswell, Amanyire, Alesi and Yam (2017:S23), health care services specifically for adolescents and young adults, particularly reproductive health care services that include family planning, are essential. However, having family-planning services available is not enough. Providing youth friendly health care services would help to address the developmental needs of young people and the unique obstacles they face, with the aim of promoting greater access to and better use of such services. The WHO has described youth-friendly health care services as services that are equitable, accessible, acceptable, appropriate, and effective for young people, and that are able to meet their needs (WHO 2012:7).

According to Hutton and Jackson (2014:13), adolescents are considered to be a specific health population, and yet the adolescent patient is often inadequately provided for within the current health care systems. Adolescents are often infrequent users of these primary health care services. To improve health care services for adolescents, their perspectives on these services should be considered and reviewed. Personal factors, organisational factors, and external factors were identified as deterring adolescents from accessing health care services.

Personal factors are issues directly relating to the individual, or how the individual feels. Issues such as confidentiality, privacy, and trust were identified as personal factors that deter adolescents from accessing health services. Organisational factors relate to adolescents' views and opinions of the health care setting and the staff. The gender of the service providers is also a concern for adolescents; since it is indicated that 73% of female adolescents aged 13–16 years prefer to be served by the same sex for consultations, where sexual health and contraceptive issues are discussed. External factors relate to external influences, such as structural issues, educational factors, and the health care systems knowledge of the needs of adolescents.

A lack of knowledge of health care services can be a major barrier to accessing health services for adolescents, many of whom do not know that primary health care services exist, or what those services are able to provide for them. Furthermore, they do not seek out health care services, because they are unaware of the treatment options available to them (Hutton & Jackson 2014:14).

According to Hosek, Harper, Lemos, Miller, Lee, Friedman and Martinez (2018:1), an HIV diagnosis can have a devastating effect on adolescents, as they have to adjust to living with a highly stigmatised health condition that will require daily medication and monitoring for the rest of their lives. An HIV diagnosis during adolescence occurs just when they are experiencing rapid biological, cognitive, social, and psychological changes, as they traverse the developmental pathway and milestones associated with adolescence and emerging adulthood. Some adolescents cope well with their HIV diagnosis, but many lack the guidance and support of family, friends, and professionals to assist them in adjusting to their health condition.

The care of adolescents who test HIV positive is often beset with a range of difficulties, as traditional adolescent developmental issues need to be integrated with the burden of living with a highly stigmatised illness. Problems can emerge, such as psychological distress (which has been associated with decreased adherence to medications), lack of social support, and an internalised stigma. These challenges are mostly felt in the first year after receiving an HIV diagnosis, as adolescents struggle with the initial acceptance of their diagnosis, feelings of depression/isolation, fears of illness/physical symptoms, and

anxiety regarding the possible disclosure to others. Disclosure is a process, and it can have either positive or negative consequences for the individual; some adolescents are afraid of possibly losing their parents and friends after disclosing their HIV-positive status.

2.4 ADOLESCENT-FRIENDLY HEALTH SERVICES

TABLE 2.1 GLOBAL STANDARDS FOR QUALITY HEALTH CARE SERVICES FOR ADOLESCENTS

Standard 1	**Adolescents' health literacy**	The health facility implements systems to ensure that adolescents are knowledgeable about their own health, and they know where and when to obtain health services.
Standard 2	**Community support**	The health facility implements systems to ensure that parents, guardians and other community members and community organizations recognize the value of providing health services to adolescents and support such provision and the utilization of services by adolescents
Standard 3	**Appropriate package of services**	The health facility provides a package of information, counselling, diagnostic, treatment and care services that fulfils the needs of all adolescents. Services are provided in the facility and through referral linkages and outreach.
Standard 4	**Providers' competencies**	Health-care providers demonstrate the technical competence required to provide effective health services to adolescents. Both healthcare providers and support staff respect, protect and fulfil adolescents' rights to information, privacy, confidentiality, non-discrimination, non-judgemental attitude and respect.
Standard 5	**Facility characteristics**	The health facility has convenient operating hours, a welcoming and clean environment and maintains privacy and confidentiality. It has the equipment, medicines, supplies and technology needed to ensure effective service provision to adolescents.
Standard 6	**Equity and non-discrimination**	The health facility provides quality services to all adolescents irrespective of their ability to pay, age, sex, marital status, education level, ethnic origin, sexual orientation or other characteristics.
Standard 7	**Data and quality improvement**	The health facility collects, analyses and uses data on service utilization and quality of care, disaggregated by age and sex, to support quality improvement. Health facility staff is supported to participate in continuous quality improvement.

Standard 8	**Adolescents' participation**	Adolescents are involved in the planning, monitoring and evaluation of health services and in decisions regarding their own care, as well as in certain appropriate aspects of service provision.

Source: WHO (2015:4)

The WHO (2015) has developed global standards for quality health care services for adolescents, in order to assist policy-makers and health-service planners in improving the quality of these services. It is envisaged that these standards will make it easier for adolescents to access the health services that they need, and will thus promote, protect, and improve their health and well-being. The eight global standards developed are as follows: adolescents' health literacy, community support, appropriate package of services, providers' competencies, facility characteristics, equity and non-discrimination, data and quality improvement, and adolescents' participation (WHO 2015:5–17). These are summarised by the WHO as shown in Table 2.1 below.

In order to meet the required level of quality in the delivery of adolescent-friendly health services, all these standards need to be met, as each standard reflects an important facet of what would constitute quality services for adolescents (WHO 2015:4).

These global standards need to be translated into national standards. According to the WHO (WHO 2015:4), "to make progress towards universal health coverage, ministries of health and the health sector more generally will need to transform how health systems respond to the health needs of adolescents". To make this transformation possible, the WHO (2014) recommends developing and implementing national quality standards and monitoring systems.

According to Lesotho's Ministry of Health (2015:35), Lesotho, like other countries, has adopted the WHO standards for quality health care services for adolescents. The Ministry of Health developed a five-year strategy to complement the efforts of other stakeholders. The interventions laid out in the strategy were intended to cover all the different places where adolescents and young people are found: homes, schools, tertiary learning institutions, orphanages, health care facilities, community centres, churches and places of worship, workplaces, community organisations, remand homes, youth centres, media platforms, law enforcement centres, judicial institutions, and rehabilitation institutions. The National Health Strategy promotes the provision of friendly health services to adolescents

and young people, as prescribed in the Quality Standards for Young People's Friendly Health Services.

The Ministry of Health has adapted the WHO standards to ensure that Lesotho has quality standards for the youth-friendly health services. The Ministry aims to incorporate the standards into various sub-sectors of the Ministry of Health and its line ministries. The eight quality standards that were developed focused on the following: accessible adolescent-friendly health care services; free access to information and services; offering services that are accepted by the youth; a friendly and non-judgemental attitude on the part of service providers; minimal waiting times; and privacy and confidentiality.
Furthermore, the National Health Strategy aims for young people to get all the relevant services they need from trained health professionals with knowledge and skills in reproductive health, sexuality and care, the treatment of STIs, mental health, and domestic and sexual violence. In the design, implementation, monitoring, and evaluation of such services, the Ministry of Health recommends that these services be provided to adolescents by well-trained health workers, and there is sufficient and appropriate medication and equipment at the delivery points for accommodating young people (Ministry of Health, Lesotho 2015:36).

The National Health Strategy (Ministry of Health, Lesotho 2015:36) further indicated that to deliver such services optimally, planning needs to take into account:

- Service location: the ART care team in the facility needs to identify convenient, comfortable, private, and accessible places, preferably areas with a separate waiting area, to offer adolescent services. These services should have a separate time or day for adolescent clinics, or a specially designated space.
- Working hours: flexible clinic hours need to accommodate care of both in-school and out-of-school adolescents. Clinic hours being extended after 5 pm, and over weekends, would benefit adolescents.

Dedicated staff who are able to identify with the adolescent person and specially trained health care workers could provide adolescent-friendly services and HIV management. The presence of job aides (youth ambassadors) is important for quality health service delivery to adolescents. Mobilising the youth by identifying, training, and using peers to

support the provision of services has been identified as important for establishing adolescent-friendly services.

In South Africa, for example, the Youth Friendly Services (YFS) programme was scaled up from the National Adolescent-Friendly Clinic Initiative (NAFCI). The programme was intended to improve the sexual and reproductive health of both young men and young women aged 10–24 years by promoting their access to and utilisation of services, and to build the capacity of health-care providers to provide YFS and to promote further services for HIV-infected and HIV-exposed young people.

Clarfelt (2014) identified the barriers that young people in South Africa face when attempting to access health services, specifically sexual and reproductive health services, at public health facilities: the lack of privacy, inconvenient clinic opening times, and discouragement by the clinic's staff, who disapprove of adolescents being sexually active. The fear of the judgmental attitudes of healthcare workers is a significant barrier to young people's use of a range of health services in South Africa (Clarfelt 2014:8). Limited knowledge about sexuality and reproductive health among young men and young women also deters them from accessing services for pregnancy and STIs.

A study by Reif et al. (2016) on the impact of a youth-friendly HIV clinic in Port-au-Prince in Haiti emphasised the importance of taking measures to ensure the long-term retention of adolescent patients. The study found that social, behavioural, and structural barriers are exacerbated by the emotional, psychological, and physical changes that occur during adolescence, and that these affect long-term retention (Reif et al. 2016:8). The stigma associated with HIV infection, isolation and a lack of psychosocial support, and economic factors, such as access to transport fees and food, were also found to negatively influence their long-term retention. These are challenges that are not easily influenced by clinic based interventions, but the establishment of a dedicated adolescent clinic improved retention immediately after HIV testing and assessment for ART eligibility, but did not increase retention after ART initiation. The youth-friendly clinics did not impact the long term retention of ART patients, which was influenced by a multiplicity of socio-economic, family, and community factors that acutely influenced adolescent behaviour, in addition to various clinical factors. However, the dedicated clinic space reduced the stigma associate with HIV and increased confidentiality, since the adolescent patients were not

required to mix with adults. Finally, it was found that training staff in youth-friendly care may have increased the adolescents' perception of the acceptability of HIV services.

Reif et al. (2016:8) strongly indicated that the WHO recommendations to improve retention in care among HIV-positive adolescents should be implemented, and that retention needs to be improved through the implementation of a youth-friendly adolescent HIV clinic. This would further improve outcomes among both pre-ART and ART patients, by increasing the proportion of patients enrolling in HIV care, being assessed for ART eligibility, and initiating ART.

Ridgeway, Dulli, Murray, Silverstein, Santo, Olsen, Mora, & McCarraher (2018) focused specifically on interventions to improve ART adherence among adolescents in low and middle-income countries. They note the improvements in access to ART for people living with HIV — between 2010 and 2015 global ART coverage increased by a third and coverage in eastern and southern Africa more than doubled (UNAIDS 2016). However, they state that these efforts that have been put in place are insufficient for ensuring positive health outcomes, as patients must be highly supportive of the ART regimens in order to achieve viral suppression and to experience the reduced likelihood of HIV-related mortality, drug resistance, and secondary HIV transmission. They also note particular problems with ART adherence among adolescents.

HIV is the second-leading cause of death among adolescents globally, and sub-Saharan Africa is mostly seriously affected by the epidemic, with an estimated prevalence of 2.2% among young women and 1.1% among young men, compared with the global estimates of 0.4% and 0.3%, respectively (Ridgeway et al 2018:1). The authors also note that 30% of new HIV infections occurred among adolescents of age 15 to 24 years in 2014 (Ridgeway et al 2018:1).

Ridgeway et al (2018) find that ART adherence is a major challenge among adolescents living with HIV in low- and middle-income countries. They refer to Hudelson and Cluver's (2015) systematic review, which found that estimated rates of ART adherence among adolescent populations varied substantially, ranging from 16% to 99% globally. Analysis of the 2014 data for adolescents and young people aged 12–24 in 53 countries showed that adherence based on self-report or viral load measures was 84% in both Africa and

Asia. However, virologic data indicated that rates of viral suppression ranged from 27% to 89% in Africa, from 52% to 87% in Asia, and from 37.5% to 49% in Central and South America (Ridgeway et al 2018: 1).

Given the social and psychological adherence barriers faced by adolescents, Ridgeway et al (2018) note that implementing companies, other stakeholders, and decision-makers are now prioritising targeted programming and differentiated care for adolescents with HIV, in response to the growing burden among young people. They report that a number of interventions have been designed to improve ART adherence for both HIV-infected adults and adolescents living with HIV (ALHIV) in low- and middle-income countries.
These included:

- a range of counselling interventions (individual adherence counselling, group adherence counselling, and individual counselling combined with group adherence counselling)
- mHealth (mobile health) interventions (SMS reminders sent at regular intervals, SMS reminders triggered by adherence monitors, interactive voice response or phone call reminders, alarm device reminders)
- community- and home-based strategies (home visits, community-based programmes, peer treatment supporters, community-based social network support)
- pharmacist counselling
- depression treatment, and
- facility-based interventions. (Ridgeway et al. 2018:1–33)

2.5 BEST PRACTICE FOR HIV SERVICE TO ADOLESCENTS

In a study on the perceptions of counsellors and youth-serving professionals about sexual and reproductive health services for adolescents in Soweto in South Africa, Mulaudzi, Dlamini, Coetzee, Sikkema, Gray, and Dietrich (2018:21) found that adolescents remain vulnerable to HIV, and that it is therefore crucial to provide accessible adolescent-friendly HIV prevention interventions that are sensitive to their needs. Understanding the perceptions of HIV counsellors and other youth-serving professionals about the barriers to providing youth-friendly sexual and reproductive health services to adolescents is very important. Mulaudzi et al (2018) found that barriers to the provision of adolescent-friendly

sexual and reproductive health services included service provider attitudes to reproductive health care services for adolescents, the clinic environment, and health care workers who were not adolescent-friendly. In addition, Mulaudzi et al (2018) found that there was insufficient service-provider training on how to test and counsel adolescents in relation to HIV, and this lack of training affected the service providers' ability to provide adolescent-friendly services.

Saul, Bachman, Allen, Toiv, Cooney and Beamon (2018:1) found that "the HIV epidemic among females aged 15–24 in sub-Saharan African countries remains uncontrolled, with 2/3 of new infections occurring in this population, or an estimated 280,000 new infections annually". They noted that AGYW in southern Africa are 14 times more likely to be infected with HIV than their male peers. Factors that make AGYW particularly vulnerable to HIV include gender-based violence, exclusion from economic opportunities, and a lack of access to secondary school. In addition, Saul et al (2018:1) note that "the population of young females in sub-Saharan Africa is expected to double from 100 million (in 1990) to 200 million by 2020". There is therefore an urgent need for programmes designed to prevent new infections in AGYW in areas with a high HIV burden. Saul et al (2018) also discuss recent systematic reviews that identify factors associated with HIV infection in young women: a history of STIs, alcohol use, multiple sex partners, early marriage, being out of school, inconsistent condom use, and engaging in transactional sex.

To respond to the realities of the context in which AGYW are living, the DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe) public-private partnership was instituted by PEPFAR (the United States President's Emergency Plan for AIDS Relief) in 2014, to ensure a multi-faceted, integrated response from the health, education, psychosocial, economic, and civil society/community sectors (Saul et al 2018:2). The DREAMS programme promotes evidenced-based interventions that are most likely to impact HIV risk behaviours and incidence among AGYW. The following are the categories of interventions implemented as DREAMS interventions:

- **Empower AGYW and reduce their risk** for HIV, unintended pregnancy, and violence through condom promotion and provision; pre-exposure prophylaxis (PrEP); post-violence care, including post-exposure prophylaxis; HIV testing

services; expanding and improving access to voluntary, comprehensive family planning (FP) services; and social asset building.

- **Strengthen families** through parent/caregiver programmes, educational subsidies for transition to and attendance of secondary school, and other socioeconomic approaches.
- **Mobilise communities for change** by educating communities about AGYW, particularly boys and young men, through school-based HIV and violence prevention programmes and community mobilisation/norms change initiatives.
- **Reduce the risk of sexual partners of AGYW** through providing their sex partners with highly effective HIV services, including HIV testing and treatment, condoms, and voluntary medical male circumcision, to better target HIV services. (Saul et al 2018:3–4)

Meeting the needs and demands of AGYW requires that the challenges and risks for individual girls or young women be accurately identified. Once identified, then and only then, can a response be tailored to mitigate risks in a holistic way. The DREAMS programme provides the blueprint for doing exactly that by implementing youth-focused HIV prevention within the parameters laid out in the DREAMS core package.

2.6 THE CHALLENGES OF HIV TESTING FOR ADOLESCENTS

According to Lightfoot, Dunbar, and Weiser (2017:1), identifying individuals with HIV infection and linking them to subsequent ART can be effective in reducing HIV transmission at the population level. However, these efforts are affected by the lack of HIV testing uptake among adolescents. There is a higher level of undiagnosed HIV infection among adolescents than among adults, particularly in sub-Saharan Africa, where only 13% of girls and 9% of boys have been tested for HIV and know their results (Lightfoot et al 2017:1).

Adolescents with asymptomatic HIV or STI-related symptoms do not seek treatment services, and those who do access the health care system are not screened for HIV. Factors that still play a role in preventing adolescents from accessing HIV services are a lack of adolescent-friendly services available during clinic hours that do not conflict with school attendance, adolescents' lack of knowledge about HIV/STIs and about the

available testing and treatment services, the costs of services or transport to clinics, and HIV-related stigma (Lightfoot et al 2017:2). Lightfoot et al. (2017:2) further indicate that when provider-initiated testing and counselling services are offered to adolescents, the health care providers are often judgmental, because they are not trained in YFS.

Parents, caregivers, and families can also affect testing in adolescents, as the identification of an adolescent's HIV status can represent the potential exposure of their parent's positive HIV status if peri-natal infection has taken place. Parents fear the stigma of HIV and the likely adverse consequences, they worry about their adolescent child's emotional reaction, and they desire to protect their children, which can paradoxically result in a lack of parental support and consent for their children's HIV testing. Some parents perceive adolescents to be at a lower risk for HIV infection, and cultural taboos can undermine conversations with adolescents about sex and HIV risks. Lightfoot et al (2017:2) conclude that "the lack of parental or family support for HIV testing is a particularly salient challenge, as allowing adolescents to consent for sexual and reproductive health services without parental knowledge is not universal across sub-Saharan Africa".

All these factors have a tremendous role to play in deterring adolescents from accessing HIV testing across sub-Saharan Africa.

2.7 SUMMARY OF THE CHAPTER

This chapter has reviewed literature on the importance of adolescent-friendly health care services, in the particular context of the HIV pandemic. The review focused on adolescents and HIV, HIV services and adolescents, adolescent-friendly health services, best practice for HIV service to adolescents, and the challenges of HIV testing for adolescents. The following chapter will describe the qualitative research methodologies applied in this study.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter describes the research methods used for this study. According to Polit and Beck (2012:743), research methods refer to the techniques used to structure a study, and to gather and analyse the information in a systematic fashion. The methodology indicates why certain data was collected, what data was collected, where and when it was collected, how it was collected, and how it was analysed. This chapter explains the rationale for using a qualitative approach and an exploratory design; indicates how the data was sampled, collected, analysed and verified; and describes the ethical considerations taken into account during the course of the study.

These methodologies were used to achieve the core purpose and objectives of this study. The study's purpose was to investigate the perceptions of adolescents on the youth friendly HIV centre at the Public hospital in Maseru. In order to achieve the purpose of the study, the following objectives were formulated:

- To explore and describe the perceptions of adolescents on the use of youth friendly services.
- To identify the best practices that could be recommended to the health care authorities, in order to scale up youth-friendly services.

3.2 THE QUALITATIVE RESEARCH APPROACH

According to Polit and Beck (2012:463), qualitative methods are used to discover the nature or qualities of something. These methods are inductive in nature, and they attempt to reveal new explanations. Qualitative approaches are flexible, and allow the researcher to gather data on topics that were perhaps not initially identified at the start of the study, but emerged during the course of the study. These methods are particularly useful when little is understood about a phenomenon, and flexibility is needed in the methods used. These methods may involve conducting semi-structured or unstructured searches; observing behaviours; conducting surveys with questionnaires that do not have a defined

set of response categories from which the participants can choose their answers, but blank spaces for participants to write their responses in their own words; or conducting semi-structured interviews with open-ended questions, during which participants are encouraged to share their responses in their own words.

Polit and Beck (2012) indicate that although qualitative research is used in different disciplines that have developed different methods for addressing particular types of questions, as a whole it has the following characteristics:

- It is always flexible, and is able to incorporate new information during the data collection process
- It tends to be holistic, and is aimed at an understanding of the whole phenomenon
  • It allows different data-collection strategies to be used in a study
- The researcher in qualitative research is the primary “instrument”, rather than the designer of objective instruments to measure particular variables
- In qualitative research, attention is paid to the impact of the researcher’s and others’ values in the course of the analysis, rather than presuming the possibility of a value-free inquiry. (Polit & Beck 2012:463)

According to Brink et al. (2012:121), the following are the characteristics of qualitative research:

- In qualitative research, the research is conducted in the real-life situation. Qualitative researchers tend to collect the data in the field, at the site where the participants experience the issue or problem under study.
- In qualitative research, the researcher is the key instrument in the process of data collection. Qualitative researchers collect the data themselves through examining documents, observing the behaviour of participants, or interviewing them. They may use a protocol — an instrument to guide the collection of the data — but the researchers are those who actually gather the information. The researcher is seen as the main instrument in qualitative research, and is subjectively involved in the research process.
- Multiple sources of data are employed for the purpose of data collection. Qualitative researchers typically gather multiple forms of data, such as interviews, observations, and documents, rather than relying on a single data source. They

review all of the data, make sense of it, and organise it into categories or themes that emerge from all the data sources.

- The purpose of qualitative research is an in-depth description and an understanding of people's beliefs, actions, and events in all their complexity. Qualitative researchers build their patterns, categories, and themes from the bottom up, by organising the data into increasingly more abstract units of information. This inductive process illustrates working back and forth between the themes and the database until the researchers have established a comprehensive set of themes. It may involve collaborating with the participants interactively so that the participants have a chance to shape the themes or abstractions that emerge from the process.
- The rationale of the research is not to generalise the findings, but rather to understand them in context. This means that qualitative research is interpretive: it is an interpretive inquiry, in which the researchers make an interpretation, based on what they have seen, heard, and understood. Their interpretation cannot be separated from their own backgrounds, histories, contexts, and prior understandings. After a research report has been written up, it is verified by readers and by the participants, offering yet other interpretations of the study. With the readers, the participants, and the researchers all making interpretations, it is apparent how multiple views of the problem can then emerge.
- Qualitative research provides a holistic account of the topic investigated, and qualitative researchers try to develop a complex picture of the problem or issue under study. This involves reporting multiple perspectives, identifying the many factors involved in a situation, and generally sketching the larger picture that emerges.

Based on the aforementioned descriptions of qualitative research and its characteristics, the researcher concluded that a qualitative approach would be suitable for answering the research question due to its flexible and non-sequential nature. It is also suitable for understanding people's perceptions and opinions, especially if the researcher (as was the case in this study) acted as an active listener, whilst the participants, acting as the "experts", shared their perceptions on the use of the HIV youth-friendly centre.

3.2.1 The research design

The research design is the overall plan and procedures employed for addressing the research question, including the specifications for enhancing the study's integrity. It is therefore a full description of how the research will be conducted (Polit & Beck 2012:743). In this study, the researcher used an exploratory research design to gain some insight into the adolescent participants' perceptions. The following section explains how the researcher utilised this research design to achieve the goals of the study.

3.2.1.1 Exploratory design

Exploratory research explores the dimensions of a phenomenon, or develops or refines hypotheses about the relationships between phenomena. It seeks to learn how people get along in the setting in question, what meanings they give to their actions, and what issues concern them. Exploratory research is used to investigate a phenomenon on which little knowledge exists (Polit & Beck 2012:728). In this study, little was known about the perceptions of adolescents on the use of the youth-friendly HIV centre. The researcher therefore selected an exploratory research design in order to explore these perceptions.

3.2.1.2 Descriptive research

Descriptive research aims at a precise representation of people's characteristics or circumstances, and the frequency with which certain phenomena occur (Polit & Beck 2012:726). Descriptive research aims to describe and document a process, event or an outcome in detail (Houser 2015:138). In addition, qualitative descriptive research is less theoretical than other qualitative approaches, making it easier to design a framework for conducting a study (Kim, Sefcik & Bradway 2017:2). A descriptive study was believed appropriate because this study wanted to describe the perceptions of adolescents on the use of youth- friendly services.

3.2.2 Research Setting

The location for conducting research could be in a natural and in a controlled setting (Grove et al 2013:709). The choice of setting for data generation depends on the nature

of the research question and the type of data required to address it (Brink et al 2012:59). Lesotho consist of ten districts which are equipped with primary, secondary and tertiary health care facilities. The study took place in the Maseru district, at a public hospital. The hospital functions from 7 am to 5 pm, from Monday to Friday and 8am to 1 pm Saturday. The hospital offers adolescent friendly health services to adolescents. Since the hospital is town is visited by people from the surrounding urban areas, semi urban and those visiting the town.

3.2.3 Population and sampling

A population is the entire set of individuals or objects that have common characteristics, or which conform to specific criteria, and from which it is intended to generalise the results of the research (Polit & Beck 2012:739). Brink et al. (2012:131) described a population as the entire group of persons or objects that meet the criteria for the research. In this regard, the population of a study comprises the aggregation of elements from which the sample is actually selected. The population of this study comprised the total number of adolescents accessing health services at the adolescent centre of the Public Hospital in Maseru.

In order to determine the group of people who participate in a study, sampling needs to be conducted. Sampling is the process of selecting some of the participants within the population to represent the entire population. Qualitative sampling requires the selection of appropriate participants, in order to best achieve the objectives of the study. Adequate sampling helps to address the research question, and to develop a full description of the phenomenon being studied.

There are two general kinds of sampling: probability and non-probability sampling. Probability sampling is a sampling process in which every person in the population has an equal chance of being selected, while in non-probability sampling one does not know the probability of a person being selected. (Brink et al. 2012:134). The researcher decided to use non-probability sampling, as it is suitable for studies in which the researcher does not know much about the population, such as its size or its demographic characteristics.

The participants in this study were purposively sampled for inclusion in the study based on their knowledge and their ability to describe the phenomenon (Polit & Beck 2012:743). Purpose sampling is a non-probability sampling method, in terms of which the researcher selects the participants based on his or her personal judgement about which participants would be the most informative (Joubert 2014:741). Purposive sampling is often used to select atypical cases rather than typical ones. This approach is commonly used in qualitative studies that seek to compare the opposite extremes of a phenomenon, in order to generate hypotheses about it. The participants thus selected help the researcher to understand the problem and to answer the research question. In a qualitative study, the sampling does not depend on the large size of the selection of participants; but it depends on how knowledgeable and willing the participants are. Furthermore, it also depends on the completeness of the overall sense of the meaning of the concept, theme, or process. It also depends on information saturation, which helps to determine when the sampling is complete. Not all participants had an equal chance of being selected. They needed to conform to specific criteria and were selected based on their presence and availability on the day when the data was collected The researcher used the following criteria for the inclusion of participants in the sample:

- Adolescents aged 18-19 years old;
- Adolescents who accessed services at Public adolescent centre;
- Adolescents who were tested for HIV at the Public hospital adolescent centre;
- Adolescents who were on antiretroviral treatment administered from the Public hospital adolescent centre;
- Adolescents who were HIV positive and were accessing psychosocial support at the Public hospital adolescent centre.

3.2.3.1 Sample size

The sample size is the number of people who participate in a study (Polit & Beck 2012:743). The sample size was determined by data saturation, that is, the point at which no new information surfaces. Polit and Beck (2012: 521–522) suggest continuing to select participants until the data can pass two tests, namely:

- Completeness: when the participants have shared sufficient information for the researcher to gain an overall sense of the meaning of a concept, theme, or process.

- Saturation: when the researcher no longer elicits new information from subsequent interviews.

There was no specific sample size established at the outset. Instead, the sample size was determined by the researcher's judgement of the point of data saturation. The researcher and the study supervisor decided when data saturation had been reached after both reading through the transcribed interviews. After nine participants had been interviewed, new interviews seemed to yield little additional information.

3.2.4 Recruitment of the participants

In recruiting participants, the researcher assessed all the possible ways in which a potential research participant might feel unduly pressured to participate. These included a personal appeal, the status of being part of a special group of adolescents, and the participant's willingness. Based on this assessment, the researcher applied the ethical principle of consent. Potential participants were clearly informed about the nature and purpose of the study, and were made to understand that there would be no rewards for participation, and no penalties for refusing to participate or for withdrawing during the study. These aspects were communicated verbally and in writing, on the informed consent form created by the researcher in conjunction with his supervisor.

The researcher started the process by providing health education to all the adolescents who used the services at the Public Hospital adolescent clinic. He then went through the patients' records to identify potential participants who met the criteria for inclusion in the study. The researcher spoke with the potential participants face-to-face and reintroduced himself, explained the purpose of the study and the criteria for inclusion, and explained to them what their participation in the study would entail. The participants were fully informed that their participation in the study was voluntary, that they had the right to refuse to participate in the study, and that if they were not willing to participate, they would not be discriminated against on the grounds of their refusal to participate.

The potential participants were then informed that the data collected would be discussed with the researcher's supervisor, would be presented to examiners and the research committee members, and would possibly be published in a journal, as an article. The

researcher assured the participants that they would remain anonymous, as their names would not be used. Instead, they would be identified as a number, so that they could not be linked to the contents of the data collected and documented. The questionnaire that was going to be used during the interview was fully explained to the participants, and they were told that the interview would be digitally recorded, but only when they had given their consent. The potential participants signed the informed consent document (see Annexure 1), thereby indicating their willingness to participate in the study.

Once the participants had agreed to participate in the study, based on the all information provided to them, the researcher arranged an interview time with them. The participants who were immediately available signed the consent forms and started the interview. Appointments were made with those who were not immediately available, and during these appointments the researcher recapped the necessary information again, after which the participants signed the consent form and the interviews began.

3.2.5 Data collection

Data collection is the precise, systematic gathering of information relevant to the research purpose or to specific objectives, or to the hypothesis of the study (Brink et al. 2012:132; Grove et al. 2013:52). The researcher in this study used a semi-structured interview as the data collection instrument, since it was suitable for achieving the objectives of the study: to explore and describe the perceptions of adolescents on the use of youth-friendly services; and to identify the best practices that could be recommended to the health care authorities, in order to scale up youth-friendly services. According to Brink et al. (2012:157), the interview method of data collection is used to obtain responses from the participants. A semi-structured interview lists in outline the general form of the questions that the interviewer should cover in the interview, but allows the interviewer to adapt the sequencing and the wording of the questions to each particular interview. The interview guide ensures that different interviewers would cover the same predetermined questions, while at the same time remaining relaxed and conversational, and being free to probe into unanticipated circumstances and responses. The interviews were conducted in either English or Sesotho those conducted in Sesotho were translated into English. The researcher is fluent in Sesotho and English, and thus had a good understanding of the

information. The interviews lasted for approximately + or- 30 minutes and were conducted for a period of a month and they conducted private room where privacy was ensured.

Before the commencement of each interview, the researcher introduced himself and asked some general questions to put the participants at ease, as suggested by Polit and Beck (2012: 543). In addition, the researcher explained to the participants what the study was about, determined who was eligible to participate, and explained how the interviews would be conducted. The researcher obtained written consent from all the participants before they were interviewed

It is important for the researcher to understand qualitative research methods very well, in order to adhere to the principles and strategies of the methods used. In relation to the semi-structured interview, the researcher used the following principles.

A non-judgmental attitude: For the participants to feel free to participate in the study fully, they needed a safe atmosphere to openly disclose all kinds of information, including private thoughts and feelings. The researcher ensured that he was non-judgmental with all the participants, in order to encourage their openness. All the participants were reassured that the information they shared was accepted, even if such information was very personal, and the researcher demonstrated this by using verbal responses and physical cues, such as nodding, to indicate his empathy and engagement.

Free expression of participants: Allowing the participants to express themselves freely while the researcher listened put the participants at ease and allowed for a free flow of conversation, which allowed the participants to provide all the necessary information. Asking probing questions also helped to ensure that the participants gave all the relevant information for the study.

Paying attention: Maintaining eye contact, nodding as the participant talked, and rephrasing the statements showed that the researcher was carefully paying attention to the participants. This is known as active listening, which is a process of observation and listening, and is a prerequisite for all other communication skills, since it precedes all other communication. This helped the researcher to get all the relevant information for the study from the participants.

Being sensitive: The researcher was friendly with all the participants, was sympathetic, and asked probing questions. This helped the participants to feel that they were not being patronised, judged, or humiliated.

3.2.6 Data analysis

Grove et al. (2013:535) describe data analysis as a technique used to reduce, organise, and give meaning to the information obtained. The process of data analysis involves making sense of textual and image-based data (Botma et al. 2014:220).

Data analysis was performed concurrently with the data collection. After each interview the researcher listened to a voice recording of the interview, transcribed the interview, and checked on the field notes taken during the data collection. This study used thematic analysis to give meaning to the data. The transcribed data was categorised into themes for the purpose of presentation by using an adapted form of Colaizzi's (1978) seven steps of analysis, as cited in Bazeley (2013:65):

Step 1: *Acquiring a sense of each transcript*: In this step, the researcher read and re-read each transcript, in order to obtain a general sense of the overall content. The researcher put aside any preconceived ideas about the phenomenon under study, in order to prevent contamination of the findings.

Step 2: *Extracting significant statements*: In this step, the researcher extracted the significant statements that pertained to the phenomenon under study from each transcript. The researcher recorded these statements on a separate sheet, noting their pages and the line numbers.

Step 3: *Formulating meanings*: The researcher formulated meanings from these significant statements. Each underlying meaning was coded into one category, which reflected an exhaustive description. Then, the researcher compared the formulated meanings with the original meanings, maintaining the consistency of description.

Step 4: *Theme clusters*: The researcher grouped all the formulated meanings into categories that reflected a unique structure of clusters or themes. Each cluster or theme was coded to include all the formulated meanings relating to that group of meanings. Thereafter, the groups of clusters of themes that reflected a particular issue were incorporated together, in order to form a distinctive construct of a theme.

Step 5: *Exhaustive description*: All the emergent themes were integrated into an exhaustive description of the phenomenon. After merging all the themes, the whole structure of the perceptions of adolescent on the use of the HIV youth centre was able to be extracted.

Step 6: *Statement of identification*: The fundamental structure of the phenomenon was be described. The researcher checked the findings for redundant, misused, or overestimation descriptions, and eliminated them from the overall structure.

Step 7: *Participant verification*: Validation of the findings in the study was sought from the research participants, through member checking, where the analysed data was given to the participants for review, validation, and commentary.

3.3 TRUSTWORTHINESS

Researchers should try to achieve trustworthiness in qualitative research, also known as rigour, in order to confirm that the findings are of use to other researchers (Noble & Smith 2015:34). The following measures of trustworthiness, as suggested by Polit and Beck (2012), were applied to ensure the rigour of this research: credibility, dependability, confirmability, transferability, and authenticity. These measures ensured the truth value, applicability, consistency, and neutrality of the study.

- *Credibility* is a measure of the integrity and quality of a qualitative study, and it shows confidence that the data is true (Polit & Beck 2012:724). Credibility was ensured by engaging deeply with the participants during the interviews, and with the transcripts of the interviews. In the process, the researcher tried to remain aware of his personal views and biases, and tried to capture the participants'

perceptions as truthfully as possible. The researcher's supervisor reviewed the data analysis to ensure that it was thorough, and the researcher validated the data through a process of member checking with the participants, where they checked to see whether their perceptions had been truthfully reflected.

- *Dependability* refers to the stability of the data over time and in similar conditions (Polit & Beck 2012:559). Dependability was ensured by utilising an external audit as a strategy. The researcher's supervisor acted as an external auditor of the data analysis process, and the researcher kept detailed records of the research process to facilitate the audit.
- *Transferability* refers to whether the findings can be made applicable in other settings or other groups (Polit & Beck 2012:747). The researcher described the research process and data analysis in detail, so that any other researcher could follow a similar research process in a similar context.
- *Confirmability* refers to whether the data that is presented and interpreted is a true reflection of the information presented by the participants (Polit & Beck 2012:560). The researcher recorded the interviews with a voice recorder and took detailed field notes to ensure that the participants' perceptions were accurately recorded and presented. The researcher's supervisor acted as an external auditor of the data analysis process, which ensured a measure of confirmability in the interpretation of the data.
- *Authenticity* refers to the extent to which the researcher presents the different perspectives of the voices of the participants in the collected data (Polit & Beck 2012:720). This was achieved by including direct quotations from the participants, in order to include their authentic voices and to add richness to the discussions. The research results were communicated by using detailed descriptions of specific themes.

3.4 ETHICAL CONSIDERATIONS

Ethics is set of moral principles that is suggested by an individual or a group, and is widely accepted. Systems of research ethics produce rules and behavioural expectations about the most correct (and appropriate) conduct towards experimental subjects and respondents (participants), employers, sponsors, other researchers, assistants and students.

In addition, the researcher obtained permission to conduct the research from the University of South Africa's Department of Health Studies Research Ethics Committee (REC-012714-039), from the Lesotho Ministry of Health Research Ethics Committee, and from the manager of the Hospital Nursing Services at the public hospital. After approval had been granted by the various stakeholders, the nurse in charge of the adolescent clinic, who acted as a gatekeeper of the participants, was approached for permission. The researcher assured the nurse in charge that the participants would remain anonymous, and that the information by the participants would remain confidential and would not to be linked to them in any way.

The researcher is responsible for conducting the research in an ethical manner — from the conceptualisation and the planning phases, through to the implementation phase, and then to the dissemination phase (Brink et al. 2012:32). Five principle for ethical research are outlined below.

3.4.1 Informed consent

According to Brink et al. (2012:32), participation in research must be voluntary. Participants must not be forced to participate, they must be made aware that they are participating in a study, they must be informed of all the consequences of the study, and they must consent to participate in it. The potential participants should be provided with information on the purpose of the study and the benefits of the study. It must be clear that participation in the study is voluntary, and that participants can withdrawing at any time, without any coercion or penalty.

Specific information was provided to the potential participants who were asked to participate in the research study, so that they could make an informed decision about whether to participate. The research topic, the purpose of the study, and the intended benefit of the study were explained to them, and they were informed that participation in the study was voluntary. They were assured that if they felt like withdrawing, they were free to do so. This information was provided both in writing (see Addendum A) and verbally. After being adequately informed and upon agreeing to participate, the participants were requested to give their consent in writing.

3.4.2 Privacy and confidentiality

According to Brink et al. (2012), the right to privacy refers to the freedom of the individual to pick and choose for him or herself the time and the circumstances under which to participate in the research. Brink et al (2012) elaborated that privacy also involves the extent to which personal attitudes, beliefs, behaviours, and opinions are to be shared with or withheld from others during and after the completion of the study. The participants' rights to both privacy and confidentiality were protected. The interviewer and the interviewee met in a private room during the data collection. No names or personal identification were reflected on the recorded data, and only codes were used. The participants were informed that the findings of the study would not be published without their consent.

3.4.3 Autonomy

Autonomy means that every person has the right to self-determination. This implies that an individual has the right to decide whether or not to participate in a study, without the risk of penalty or prejudicial treatment (Brink et al. 2012:35). The participants were assured that they were free to refuse to participate in a research study, and that they could withdraw from the research study without incurring any penalty. The decision to participate in the study was at all times voluntary (Brink et al. 2012:35). The participants had the right to refuse to participate, or to give any information, even after signing the information consent form.

3.4.4 Beneficence

The participants had the right to protection from discomfort and harm, be it psychological, spiritual, economic or legal (Brink et al. 2012:35). The researcher therefore ensured the wellbeing of the participants, by questioning and probing in a way that did not emotionally hurt the participants. The participants' culture was also respected, and the researcher was non-judgemental thereof.

3.4.5 Justice

Fairness to all the participants was practised and promised. For example, the researcher stuck to the agreed meeting times, as promised. Potential participants were assured that their names would not be mentioned anywhere in the research project. Anonymity was ensured by allocating each participant a code name, so that their identity would remain anonymous. The participants' responses and other recorded information were kept confidential, and were not accessible to any other person who was not part of the research project (Brink et al. 2012:36).

3.5 SUMMARY OF THE CHAPTER

This chapter has described the research methods used for this study The rationale for using a qualitative approach and an exploratory design was explained, after which the processes of participant sampling, and data collection, analysis and verification were explained. The ethical considerations taken into account during the course of the study were also described. The following chapter presents and discusses the research findings.

CHAPTER 4

PRESENTATION AND DISCUSSION OF THE RESEARCH FINDINGS

4.1 INTRODUCTION

The previous chapter described the research methods used for this study. It discussed the rationale for using a qualitative approach and an exploratory design, and indicated how the data was sampled, collected, analysed and verified. It also described the ethical considerations taken into account during the course of the study. This chapter presents and discusses the research findings from the individual, semi-structured, in-depth interviews conducted with nine adolescents who accessed the health services at the Public Hospital adolescent clinic. As discussed in detail in section 3.2.5 in the previous chapter, data analysis was performed on the transcribed interviews using an adapted form of Colaizzi (1978) seven steps of analysis, as cited in Bazeley (2013:65). The field notes taken during the data collection were used to supplement the analysis.

The main objective of the chapter is to provide a critical presentation of the results, in order to provide a foundation for answering the research questions:

1. What are the perceptions of adolescents on the use of the youth-friendly services?
2. What recommendations could be made to health care authorities regarding the use of the youth-friendly services by the adolescents?

The findings are described and presented in a narrative format. Verbatim excerpts from the participants are presented to support the findings, which are integrated with the relevant literature. The findings are structured according to six primary themes that emerged during the data analysis, each of which has a number of sub-themes.

4.2 DEMOGRAPHIC PROFILE OF THE PARTICIPANTS

A demographic profile of the participants — in terms of their age, gender, and whether they still attended school or not — is presented in Table 4.1 below.

TABLE 4.1 DEMOGRAPHIC PROFILE OF THE PARTICIPANTS

Participant profile	Number of Participants
Total number of participants	9 participants were interviewed
Age of participants	56% (n=5) participants were 19 years old
	44% (n=4) participants were 18 years old
Gender of participants	67% (n=6) were girls
	33% (n=3) were boys
School attendees or no longer in school	67%(n=6) were school attendees
	33%(n=3) were no longer in school

4.2.1 Age of the participants

The ages of the participants ranged from 18–19 years. Nine participants were interviewed, five of them were 19 years old, and four of whom were 18 years old. According to the WHO (2012:2), adolescence is a period during which an individual undergoes major physical and psychological changes. During this growth process, there are enormous changes in social interactions and relationships. Adolescence is a time of opportunity, but also one of risk. It presents a window of opportunity because actions could be taken during this period to set the stage for a healthy adulthood and to reduce the likelihood of problems in the years that lie ahead.

At the same time, it is a period of risk, when health problems that have serious immediate consequences can and do occur (such as deaths resulting from road traffic injuries, and STIs and unwanted pregnancies resulting from unprotected sexual activity). It is a period when problem behaviours that could have serious adverse effects on health in the future (such as tobacco smoking and alcohol consumption) are initiated.

4.2.2 Gender of the participants

Most of participants were girls. Of the nine participants, six were girls and three were boys. According to Bogle (2013:8), males have poor health seeking behaviour due to a number of factors like masculinity. Masculinity refers to dominant ideals about the qualities of a ‘real’ man, which include stoicism, appearing strong and brave, and risk taking. These deep-rooted culturally held social norms are said to influence men’s behaviour, and one consequence is that men may avoid accessing healthcare as a demonstration of the strength component of masculinity. Furthermore, Bogle (2013:3) explained that looking after one’s health has been socially constructed as a feminine preoccupation, and that women are perceived to over-utilise health care services, and to present with non-serious health problems. Bogle (2013:4) also points out that men are disadvantaged when it comes to medical consultations: it has been found that their medical consultations are significantly shorter than women’s, they are given fewer and briefer medical explanations, and they are found to receive less preventative health advice than their female counterparts.

4.2.3 School attendance or non-attendance

Most of the participants were school attendees. Of the nine participants, six were school attendees, and three had left school. It has been shown that school health services are not well implemented in Lesotho, and that many adolescents therefore come to clinics to treat minor illnesses and to seek information. According to the WHO (2012:34), schools provide a natural entry point for reaching young people and providing them with health education and services. In order for schools to deliver this, they need sufficient resources and teachers who are trained to deliver health education on top of their existing workload.

The training of young people to be peer educators in schools can help with health education, and with following up on students who need to be linked to health services for testing and treatment for a range of conditions. Peer educators would help to strengthen health education and counselling-referral services, which help to decrease unwanted pregnancies and STIs, and also to improve the uptake of reproductive health services to young and unmarried people.

Having school health services with trained teachers in each school to teach learners about sexual and reproductive health, and about how students can keep themselves safe, and having students trained as peer educators to advise fellow students and start informal discussions would help to reduce the number of students who have to leave school during school hours to access health services at clinics. Health education, and some elements of counselling and referral services, would become more easily accessible to adolescents who are still learners.

For adolescents who have already left school, in both urban and rural areas, there is a need to provide services away from hospitals and health centres, in order to reach out to young people who may be unlikely to attend due to the various practical and psychological barriers to health care access for adolescents described in Chapter Two. Such services could be provided in shopping malls, as well as at community or youth centres. Services should not only be provided for adolescents within existing hospital and clinic catchment areas; but should also be designed for adolescents in remote rural areas, who are often excluded from routine health services. Outreach initiatives and mHealth services have the potential to reach adolescents everywhere.

4.3 PRESENTATION AND DISCUSSION OF THE THEMES AND SUB-THEMES

Table 4.2 shows the themes and sub-themes that emerged from the thematic analysis of the interviews with the nine adolescent participants who accessed health services at the Public Hospital adolescent centre in Maseru, Lesotho.

TABLE 4.2 THEMES AND SUB-THEMES

MAIN THEMES	SUB-THEMES
4.5.1 Outline of attributes experienced during visit to health care facility by adolescents	4.5.1.1. Visit to health care facility associated with several factors 4.5.1.2. Existing methods of care to address adolescents' needs 4.5.1.3. Organised management of adolescents' health care experience 4.5.1.4. Different adolescent services leading to uptake of HIV services 4.5.1.5. Description of the reception experienced at the health facility
4.5.2 Adolescents' perceptions of the health care facility	4.5.2.1. The adolescent-friendly environment at the health care facility 4.5.2.2. The health care facility encourages adolescents to be transparent about their health problems 4.5.2.3. Non-judgemental attitude of health care professionals and adolescents' feelings of self-worth
	4.5.2.4. Existing motivational counselling geared towards health decision-making by adolescents 4.5.2.5. Success stories related to disclosure of HIV+ status shared amongst youth at the facility
4.5.3 Adolescents' description of waiting times at the health facility	4.5.3.1. Adolescents' conceptions of reasonable versus unreasonable waiting times 4.5.3.2. Health education is provided through different media during waiting times 4.5.3.3. Appreciation of apologies given to for unreasonable waiting times 4.5.3.4. The first-come, first-served principle and the handling of emergency situations
4.5.4 Facts related to HIV counselling	4.5.4.1. Pre-counselling leads to voluntary counselling and testing, acceptance of results and adherence to positive living

		4.5.4.2.	Group health education leads to voluntary HIV testing
		4.5.4.3.	Pre-test counselling prepared adolescents to take an HIV test
		4.5.4.4.	Post-test counselling is a learning opportunity on various aspects of HIV/AIDS
4.5.5	Description of services for adolescents' health	4.5.5.1.	Processes followed for referral to psychologists
		4.5.5.2.	Feedback processes on the services provided
		4.5.5.3.	Services were recommended to friends and relatives
		4.5.5.4.	Health education leads to understanding disease processes and adherence to treatment
		4.5.5.5.	Description of ethical standards adhered to during care
4.5.6	Challenges faced by adolescents in relation to their HIV-positive status	4.5.6.1.	Rejection by sexual partners
		4.5.6.2.	Feelings of depression, despair, and suicide
		4.5.6.3.	Self-blame and shame experienced after the initial diagnosis

4.3.1 Theme 1: Outline of attributes experienced during visit to the health-care facilities by adolescents

The researcher was interested to find out why the participants came to the adolescent corner, how their needs were addressed, and how they perceived their reception at the adolescent corner.

The following sub-themes emerged, confirming the attributes experienced by the adolescents during visitation to the adolescent corner.

4.3.1.1 Sub theme 1.1: Visit to health care facility associated with several factors

The findings showed that some of the participants visited the adolescent clinic because they were feeling sick, while others visited for a medical check-up. Participant 1 said *It was time for my medical check-up, so that's why I came to the facility today.*

At this clinic, adolescents who were sick were seen from Monday to Friday. Some participants had come to collect their antiretroviral treatment. These participants had been tested for HIV and had initiated their ART at the adolescent clinic. These services were provided from Monday to Saturday. Participant 6 reported that *I came today because during the course of the week I am not able to come because I am attending school. So,*

I have a lot of questions that relate to my sexuality that I want the health care workers to help me with. Some participants had simply come to ask for information after youth ambassadors had visited their school and had made them aware of the availability of the adolescent clinic and the services that were being provided there. Participant 3 said that *I am not able to discuss some of the sensitive issues with my mother, so I felt like the only help is for me to come to the centre, where I can talk to the services providers.*

These statements also support the WHO's (2012:3) finding that health care workers are part of a key group of stakeholders who need to contribute to the health and development of adolescents. They have to help adolescents to stay healthy, and those who are ill to return to good health. This can be done through providing information, advice, counselling, and clinical services aimed at promoting health and at preventing health problems and problematic behaviours.

4.3.1.2 Sub-theme 1.2: Existing methods of care to address adolescents' needs

The findings showed that the participants attended the adolescent clinic because it addressed their needs as adolescents. Participant 2 said that *I like accessing my services at this centre because we don't mix with adult patients; and every service is provided under one roof, which makes the space very private and comfortable to avoid being labelled with diseases.* This meant that they are able to access the health services that they needed as adolescents. They received a very warm welcome and were greeted in a respectful manner. Furthermore, they were not made to wait in long queues before they could access health services. The fact that they could access health services without mixing with the adult patients enabled them to relax, and they felt comfortable to access the services. Accessing a number of health services at one site makes the particular services and treatments more private and confidential.

The fact that most services were provided from Monday to Saturday was very convenient for those adolescents still at school, and for those who worked. Participant 5 indicated satisfaction by saying that *the centre provides services from Monday to Saturday and this means that I have a lot of choices of when to come for health services. Asking permission from school to access health service is difficult at times due to examinations; so the centre being able to provide services over the weekend is an added advantage for us*

adolescents who are attending school. Health education was also provided to the adolescents in the waiting room, enabling them to have access to relevant information for their health. Young service providers were available for them to ensure that they could ask questions freely and get relevant information that addressed their concerns as adolescents. There is always a youth ambassador in the reception area, who is able to give guidance to adolescents when they come to the clinic, in order to ensure that they are in the right queue for the purpose of their visit, and don't have to wait for a long time before they can be attended to. A sign at the gate shows the services that are available at the facility, and the time that the facility opens and closes on different days.

The participants indicated that health care services can meet adolescents' needs, but only if they are part of a comprehensive programme. The package of basic health services must be tailored to accommodate local needs, reproductive health services, and counselling and voluntary testing for HIV and other STIs. Their comments also indicated that adolescents need a safe and supportive environment that offers protection and opportunities to access health services, to seek counselling to address their health problems and deal with any personal difficulties, to gather information, and to develop the skills to understand and interact with the world. The participants indicated that the adolescent clinic was a safe space for them, and that they always felt relaxed and comfortable at the centre.

The WHO (2012:5) recognises a number of factors that prevent adolescents from accessing health services. These barriers are related to the availability, accessibility, acceptability, and equity of the health services. Health care facilities may provide services, but not the services that adolescents need, like STI management and emergency contraception. Even if the services are available at some facilities, adolescents may be unable to obtain them for a variety of reasons, like restrictive laws and policies that may prevent some health services from being provided to some groups of adolescents, like the provision of contraceptives to unmarried adolescents. Adolescents can become frustrated at not knowing where and when health services are provided, as health care facilities may be located far from where they live, study, or work. Health care services are sometimes also expensive, and therefore beyond their financial reach.

At some facilities, services may be provided but not in the way that adolescents need, which discourages adolescents from accessing them. They may have to wait for a long time before being attended to; they could be seen by people they know, who may ask questions or pass judgement; they may fear that health workers will scold them, or ask them difficult questions; they may fear being put through unpleasant procedures; they may worry that the health care workers will not maintain their confidentiality; and the services providers may not be friendly to some of the adolescents.

4.3.1.3 Sub theme 1.3: Organised management of adolescents' health care experience

The findings showed that the adolescent clinic was well organised, and that there was a good patient flow. On entering, they were assisted by a person at the reception, who guided them on which queue to join, based on the service that was required. There was also a waiting room that was private; this was where health education or group counselling could be conducted confidentially for all people who accessed the health care services. The health education was delivered in different ways. On some days it was done through videos being screened, while on other days there was a youth ambassador or peer educator available for questions. This was confirmed by Participant 7 who said that *When I get to the centre, even if it is for the first time, I don't struggle, as there is always the youth ambassador to give directions, based on my health needs*.

The waiting time before getting attended to differed according to the service being accessed. Patients who had come for a medical consultation generally twenty to thirty minutes for their consultation. The maximum waiting time was forty minutes. Patients who had come for an ART refill could spend up to two hours, depending on how the different counselling sessions had been organised, or the patients had been appointed. Some patients were appointed for psychological counselling, while others joined the peer support groups.

4.3.1.4 Sub-theme 1.4: Different adolescent services leading to uptake of HIV services

The participants reported that the adolescent clinic provided a range of health care services for adolescents, and that the provision of comprehensive health care services for adolescents was integrated with the HIV services. The following services were provided for adolescents: HIV prevention education and provision of condoms (by nurses and peer leaders); pre-exposure prophylaxis (PrEP) for HIV prevention; HIV testing services; HIV treatment and ART refill appointments; pregnancy testing and maternal and child-health services (MCH); contraception; post-violence care and post-exposure prophylaxis (PEP); voluntary medical male circumcision (VMMC); private counselling; psychologist and social worker counselling; peer-support groups; treatment guidance; preparing for adult care; caregiver/parent support; and linkages to the community. This was confirmed by Participant 3 who said that *I have learned about PrEP services on how to protect myself against HIV. I learned that I am at risk of HIV infection, since I had a problem with an STI.*

HIV-testing services (HTS) are integrated into all the services. This was supported by Participant 6 who said that *I came to this facility for pregnancy testing, as I was no longer seeing my menses.* This means that all the patients are encouraged to test for HIV. Participant 6 said that *This is the best clinic to get contraceptives privately without people knowing; and it is an embarrassing thing for us young people to use contraceptives in the eyes of the community.* Those who test negative for HIV are put onto an HIV-prevention programme, and those who test HIV positive are linked to care and treatment. Health education is delivered by youth ambassadors, some of whom are living with HIV, and they share their testimonies on how they tested for HIV and how they are coping with living with the disease. Participant 3 said that *What makes me like this centre more than anything else is being served by young service providers, where the language is common; and they provide guidance to us about the services provided.* This encourages adolescents to test, as they can see that HIV testing is not a problem, that being diagnosed with HIV is not the end of one's life, and that one can still live a normal life, and achieve one's goals. This was concurred by Participant 9 who said that *When I saw those young people encouraging us to test and saying they can also test us for HIV, I felt reassured that for my privacy and confidentiality, I am covered. This was further supported by* Participant 2 who said that *Accessing health services without mixing with adults makes me relaxed, even though I am HIV positive; and I have to access my services where I am free from being judged, because I did not decide to be HIV positive.*

According to Namibia's national guidelines (Republic of Namibia Ministry of Health and Social Services 2012:3), HTS is a critical entry point to care. This means that health care providers must initiate testing and counselling with all adolescents who come to the adolescent clinic. An early diagnosis benefits patients and health care providers, as it makes the management of their health condition easier. This means that adolescents must be provided with knowledge, and that all barriers to them being tested — like the stigma associated with HIV, the inconvenient hours or location, the negative attitudes of health care workers, the lack of confidentiality, and the fear of forced disclosure — need to be addressed. More adolescent-friendly health care would help to see more adolescents being tested for HIV and accessing treatment.

This argument is supported by Reif et al. (2016:8), who found that it was important to improve retention in care among HIV-positive adolescents. The establishment of a dedicated adolescent clinic has been shown to improve the retention of adolescents. This should further improve the outcomes among both pre-ART and ART patients, by increasing the proportion of patients who enrol in HIV care, who are assessed for ART eligibility, and who initiate ART. The dedicated clinic space also reduces the stigma of HIV infection and increases confidentiality, since the adolescent patients do not mix with adults. Finally, training health care staff in youth-friendly care may increase the acceptability of these services.

4.3.1.5 Sub-theme 1.5: Description of the reception experienced at the health facility

The findings showed that the adolescent clinic's staff were very friendly. This was confirmed by Participant 1 who said that *When someone brings the street language that I am used to, this makes me feel like being at home, because it makes the clinic not too formal, and this makes me relaxed. This is how they talk to us: 'Eitha my brother, sharp ho joang? How can I help you?'*

The participants indicated that the service providers greeted and talked to them in a respectful manner, and they communicated in adolescent language. There was always a person at the reception to welcome adolescents to the facility. That put the adolescents at ease, even those who had come to the facility for the first time, as they were not

confused about how and where to access services. These findings were confirmed by Participant 5 who said that *I come to the clinic every month for my treatment refill and the welcome that I get at this clinic is amazing, and that's why I always keep coming for my check-up. This is how I get welcomed: 'Hi my sister, sharp ho joang? How can I help you?'*

The person who welcomed the adolescents to the clinic was a young person, and this made it easy for the other adolescents to relax and get comfortable and feel welcome at the clinic. The service providers working at the clinic were also young people who did not have an attitude, who did not judge, and who did not shout at the adolescents, no matter what type of service they had come to access. The service providers always asked the adolescents whether they had already been helped, and this made them feel cared for and valued at the clinic.

This is supported by the WHO (2012:4), who stated that in order to make health services adolescent-friendly, the health services should be delivered in a way that makes adolescents want to access them. Being made to wait in long lines, having health care workers scold them, being asked difficult questions, and being put through unpleasant procedures can render the health service unfriendly and make adolescents feel unwelcome.

4.3.2 Theme 2: Adolescents' perceptions of the health care facility

According to Hutton and Jackson (2014:13), adolescents are considered to be a health population that is often inadequately provided for within the current health care systems. Adolescents are often infrequent users of primary health care services, so in order to improve health care services for adolescents, their perspectives on the services should be considered and reviewed.

The following factors have been identified as affecting adolescents' access to health services: personal factors, organisational factors and external factors. The personal factors are explained, as being issues that are directly relating to the individual or how the individual feels. These issues include confidentiality, privacy and trust. The organisational factors are explained as adolescents' views and opinions of the actual general practice setting and staff.

The gender of the service providers is also a concern for the adolescents; as it is indicated that adolescents aged 13–16 years preferred to be served by the same sex for consultations in which sexual health and contraceptive issues are discussed. The external factors are the external influences, such as structural issues, educational factors and knowledge regarding the health system and the needs of the adolescents. A lack of knowledge by the service providers is the major barrier to accessing health services for adolescents of all ages. If the services provided and treatment options available at the health facility are not fully displayed, this makes it difficult for the adolescents to seek health services.

The participants expressed their perceptions of the health care facility, focusing on the attitudes of the services providers, the counselling services provided, and the motivation and positive attitude they felt when the youth ambassadors and their peers shared success stories about living with HIV. The following findings were pointed out, as explained below on the different sub-themes.

4.3.2.1 Sub-theme 2.1: The adolescent-friendly environment at the health care facility

The findings showed that when adolescents got to the facility they found a dedicated space in which adolescents were being attended to without having to mix with adult patients. Participant 8 said that *the fact that when I come to this clinic I don't mix with adult patients makes me more relaxed and comfortable; and this enables me to ask as many questions as possible.* They also indicated that the services were being provided by young people, and that youth ambassadors were available as a gateway for them to reach the appropriate services providers. The services being provided under one roof ensured privacy and confidentiality because people could not identify which adolescents had come for which services, and the queues were not labelled. Participant 7 narrated that *What I like most here, which is very different from other facilities, is that we are not labelled according to services that we are going to get. The waiting room is for one and all of us go to the same health-education session. Unlike in other facilities, where if you are coming for treatment, or a refill, you have to get your own specific waiting place.* Participant 6 concurred with participant 7 by saying *Coming to this clinic protects me from*

being stigmatised, or discriminated against about my health condition as the consulting rooms are not labelled. So even if the very same adolescents come to the facility they will not be able to know what my health problems are, unless I tell them. So, I feel 100% protected, private, and confidential.

This is supported by the design of the health services delivery for adolescents in the National Health Strategy (Ministry of Health, Lesotho 2015:36). The location of the ART services for the adolescents were convenient, comfortable, private, and accessible, with a separate waiting area in order to be adolescent-friendly.

Furthermore, the services were provided within flexible clinic hours that accommodated both school-going adolescents and those who had left school. The clinic stayed open late — after 5 pm and over weekends — for the benefit of all adolescents. The findings showed that flexible hours for the services really did help, since the adolescents could be attended to at different hours, depending on their different occupations. Some were at school, while others had left school and were working. Services at this adolescent clinic ran from 7.00 am to 5.00 pm from Monday to Friday, and 08.00 am to 1.00 pm on Saturdays. This satisfied Participant 1 who said that *The facility accommodates us adolescents, who are school attendees, as we are free to come for any service at the weekend.*
The flexible hours ensured that the adolescents who were working could access health care services early in the morning or after hours, and also over weekends.

The availability of music and television at the adolescent clinic was a matter of great importance to the participants. Participant 2 said that *I enjoy the availability of music at the centre, as even if there is no one I know at the facility that I can talk to, music or television is there to talk to me.* While they were waiting to be attended to, they could reduce boredom and also absorb some of the educational messages that were designed to improve the health knowledge of adolescents. Some participants indicated that the location of the adolescent clinic made it friendlier, because it was located in the centre of the city and was therefore easily accessible. Participant 7 said that *the adolescent centre is located in the centre of the city, and this makes it easy to access, as even when I am sent to city malls, I am able to pass by the clinic and get my services, without my parents knowing. At times, we have health problems that cannot be explained to parents. Issues*

like sexually transmitted diseases. This was supported by Participant 4 who said *I am able to come to the facility early in the morning, before I go to work, and get my treatment; and this has helped me, since my salary has not been cut. There is a policy at my work of no-work no-pay.* They were able to access it after school or when they went to town, without even having to ask permission from their parents.

This is supported by the WHO's (2015:4) finding that adolescents have different expectations and preferences. Just as Participant 3 reported that *Service providers always provide the services that I need, without judging me; and if there are problems, they always provide clear explanations to me for why they are not giving me what I want, and they provide an alternative package of services.*

They want to be treated with respect, and to be sure that their confidentiality is protected. The attitudes of the services providers also influence whether adolescents consider the facility to be adolescent friendly, and this means that service providers have to have a friendly, non-judgemental attitude and demonstrate competency when delivering the right health services in the right way. Adolescents should also be aware of where they can obtain the health services they need, and they should be both able and willing to do so when necessary.

4.3.2.2 Sub-theme 2.2: The health care facility encourages adolescents to be transparent about their health problems

The findings showed that the adolescents wanted to be treated fairly, and that they wanted services to be provided in a transparent manner. The adolescents indicated that the openness of the service providers helped them to build a rapport with them. Participant 8 echoed this by saying *the service providers at this facility are amazing. The way they treat us, talk to us, makes us believe and trust them. This makes us relaxed, and it causes us to share even some of the private issues.*

This made them feel that their personal perspectives on the health services were being considered, and that their need for confidentiality, privacy, and trust relationships was being respected as reported by Participant 9 who said *the nurses, counsellors, and youth ambassadors at this clinic are so humble and reliable; whatever I discuss with them, it ends there. I would be lying if I can say for the past six months that my private issues that*

I told them I have heard people talking about them from outside the clinic. The following comments from the participants substantiated the importance of openness, confidentiality, privacy, and trust:

The participants further indicated that the setting of the health facility and the way patient flow was designed ensured that all adolescents were attended to equally. The fact that staff were available all the time, were able to provide services early in the morning, and did not make adolescents wait for a long time in queues ensured the transparency of the services and built the adolescents' trust in their service providers.

The services were also provided by young male and female service providers, youth ambassadors, counsellors, nurses. Participant 5 reported that t*o be honest, it is not easy at times to open up to the opposite sex, especially, when I have a sexually transmitted disease. The nurse will definitely want to see what is going on at one's private parts. It is not easy for us boys; and we end up falsifying the illness, when we find the female nurse to avoid showing one's private parts to her. At this clinic, I am free to choose the type of service provider — whether a male nurse or a female; and this makes services much more comfortable.* This made it easier for the adolescents to feel relaxed, since they were able to choose to be served by whomever they felt most comfortable with. Furthermore, the service providers were knowledgeable, and this helped the adolescents to get accurate information and dispel any myths they had. Participant 7 echoed that by saying *I am happy as a person, because the service providers always address my health needs, as those of an adolescent. These guys are experts; they know their work, and everything I want I get. I never knew that if I am HIV negative I can be HIV negative for ever. They provided me with knowledge and a package of preventive services to help me remain HIV negative. I tell you that I will be HIV negative forever.*

The education that was provided gave the adolescents an accurate picture of real life — how at risk they were as adolescents and what factors could also put them at greater risk. Preventive services and counselling sessions were also available to those who needed them.

The adolescents indicated how the health care facility encouraged them to be transparent about their health problems.

According to Hutton and Jackson (2014:13), to improve services for adolescents, their perspectives on health care services should be considered and reviewed. Participant 8 revealed that by saying that *As a girl, this is the clinic for the first time I came to ask for contraceptives; and I got a detailed health education that really addressed some of the myths about contraceptives from my peers.*

They identified various personal, organisational, and external factors that prevented adolescents from accessing health services. These can really have a negative impact on adolescents' access to health services if they are not properly addressed. These factors included:

- Lack of confidentiality, privacy and trust
- Gender of the service providers
- Lack of knowledge of health care services.

These can be major barriers to accessing health services for adolescents of all ages. Many adolescents do not know what primary health care services exist, or what those services are able to provide for them. As a result, they do not seek out health services, because they are unaware of the treatment options available to them.

4.3.2.3 Sub-theme 2.3: Non-judgemental attitudes of health care professionals and adolescents' feelings of self-worth

The findings indicated that adolescents wanted to be served by the service providers who were knowledgeable and always gave them the right information about the current services available and the means of prevention that needed to be followed. They indicated that the services providers at the Public Hospital adolescent clinic delivered health education confidently, and even during counselling sessions, to ensure that the adolescents were equipped with enough information for positive living. These findings were confirmed by the participants as follows:

The findings also indicated that the adolescents liked to be treated with respect and did not want service providers who shouted at them, scolded them, or embarrassed them. Participant 7said that *as much as we are young we still need to be respected; the fact that at this clinic we are not shouted at or scolded, and we are addressed as adult people,*

no matter what, makes us feel much respected. This was further stretched by Participant 5 who said that *It's very embarrassing to bring STIs to the clinic, and the service providers starting to judge me — it's more than embarrassing. I never felt judged by the nurses.* They indicated that they did not want the service providers to adopt a parental role and values when they attended to them, but wanted them to maintain professional values, especially when they were seeking treatment for an illness like an STI, or when they came for contraceptive services. They further indicated that they enjoyed consulting with service providers who were same gender as they are, as this helped them to relax and feel comfortable. Participant 6 reported that *I am now medically circumcised after I was educated on how it reduces the transmission of HIV by 60%. The male nurse at this clinic at times talks to us boys, and the language is so clear and understandable, as we are all males.*

It encouraged them to share information that they were not able to discuss with their parents and their friends, due to the trust relationships that they had built up with those service providers. Participant 3 said that *the nurses in this clinic are young, and this makes us feel free to ask questions and get enough information without being shy when we talk about sexuality, which is something that our parents never talk about to us*.

The WHO has developed global standards for quality health care services for adolescents. These standards assist policy makers and health service planners in improving the quality of health care services so that adolescents find it easier to obtain the health services that they need, in order to promote, protect, and improve their health and well-being. The eight global standards developed include the service provider's competencies in relation to health services for adolescents, as well as equitable and non-discriminatory attitudes toward the adolescents (WHO 2015:4). Participant 3 reflected this by saying that *for the first time when I came to this clinic I never felt that it was for the first time, due to the love and appreciation of the service providers. There are people called youth ambassadors, and they always make me feel welcome, and that made me to start building a trusting relationship with the service providers.* Furthermore, the WHO (2012:3) confirms that for adolescents to access health services, they need health service providers that are non-judgemental and considerate in their dealings with adolescents, and have the competencies needed to deliver the right health services in the right way.

4.3.2.4 Sub-theme 2.4: Existing motivational counselling geared towards health decision-making by adolescents

The findings indicated that the group counselling that was conducted with every adolescent who came to the facility really helped adolescents to open up and make the decision to be tested for HIV. Structured health education was facilitated every hour, to allow for information to reach the adolescents who arrived at different times. After receiving group counselling, while still waiting to be attended to, adolescents were exposed to videos that educated them on the importance of knowing their HIV status. Participant 1 echoed this by saying that *Watching different stories of adolescents talking about their HIV status on TV made me feel that if I don't know my status, then I am a coward.*

The participants indicated that being in one room to hear adolescents talk openly about the importance of knowing their HIV status and assuring them that they would be tested by young people, makes them relaxed and helped them to make the decision to be tested. They were also told about the support services that would be provided to them after testing, depending on their HIV status. Participant 3 said that *HIV testing helps me to know exactly what package of services I need after getting my results.* This was supported by Participant 6 who revealed that *I never thought testing for HIV is so important, based on the preventive and support services that can be provided to me, based on my HIV status.*

Prevention services were explained to those who tested HIV negative, and these included the following: risk assessment/prevention, repeat testing for at-risk adolescents, provision of condoms and STI services, active linkage to other services like gender-based violence prevention, orphans and vulnerable children's programmes, PrEP and post-exposure Prophylaxis, VMMC, behavioural change counselling, education on sexual reproductive health and rights for contraceptives, cervical cancer screening, and fertility awareness.

For those who tested HIV positive, services included the following: rapid ART initiation (same day when possible), a comprehensive care package that included tuberculosis screening, prevention of mother-to-child HIV transmission, antenatal and post-natal care, early infant diagnosis of their children, nutrition screening, management of contraceptive services, STI screening, viral load monitoring and appropriate management of high viral

load, provision of adherence and support counselling, risk screening, and active linkage to other services such as gender-based violence prevention, orphans and vulnerable children programmes, enrolment in peer-support groups (mixed, boys only and girls only), multi-month prescriptions for stable patients, and mental health and psychosocial support. The participants indicated that they felt that they would be supported after being tested, and that they were not just being tested in order for the service providers to know their status. With all this information, they were comfortable deciding to get tested, even if they had come to facility for other reasons and not specifically for HIV testing.

According to Lesotho's HIV testing policy (Ministry of Health, Lesotho 2017:30), group counselling is done to avoid lengthy individual pre-test counselling sessions. It allows the HIV-testing providers to target more people at once, in order to give more time for the one-on-one sessions, which are sessions focused on and specific to the individual's circumstances. This integration was revealed by Participant 7 who said that *Being in one room with other adolescents and being educated about HIV and seeing other adolescents so calm, made me realise that testing for HIV is not such a bad thing after all.* Individual risk assessments should be carried out during the pre-test counselling. The following information is always covered confidentially: the test results and any other information shared by the client, the benefits of HIV testing, the meaning of an HIV-positive and an HIV-negative test result, and a discussion of HIV-prevention options.

4.3.2.5 Sub-theme 2.5: Success stories related to the disclosure of HIV-positive status shared amongst the youth

The findings indicated that the adolescents were very happy that the youth ambassadors were always available at the facility to share their success stories in relation to HIV testing and treatment. During such story-telling, the adolescents were able to share the experiences of other adolescents who had been living with HIV, and who therefore had experience of testing and treatment. Participant 1 said that *there is life, hope, and I can still achieve my dreams — even if I am HIV positive. I got courage from people that were talking about their positive HIV status to us. After being diagnosed HIV positive, I told myself that if others are coping to live with the disease, then I would also survive.* They could think about their stories, learn from them, and prepare for their future if they agreed to go for HIV testing and were diagnosed HIV positive. Each story had a character, a

situation, a turning point, and a result. The stories shared sounded familiar to the participants, as adolescents living with the HIV experience are common across Lesotho.

The discussion helped the participants to identify what could be learned from the successes and failures of the stories they heard and offered them real life lessons. Some of the participants commented as follows:

These findings support those of Teasdale et al. (2016:e56), who find that health care workers should provide targeted services tailored to the specific needs of adolescents and youths, including dedicated adolescent care clinics, peer-support groups, and sexual and reproductive services, in order to improve care outcomes. The detailed provision of relevant information from their peers during the support group helped the participants to make informed decisions that would benefit them. Participant 8 said that *the questions they were asking when telling us their stories, like how does the story make me feel? And can this happen to any person? These questions made me realise that being HIV infected could take away my human rights.* The participants reflected the real-life experiences behind the session topics discussed at the technical consultation. Participant 2 reflected this by saying that *I thought people that are living with HIV are dying people, look very sick, emaciated, but seeing some beautiful girls and very handsome boys well-nourished and very fit, saying they are living with HIV, I did not believe it, and I thought they have given them money, in order for them to say they are HIV positive.* Their voices helped shape the discussions, while giving personal examples of the issues. In support of that, Participant 6 revealed that *It was my first time to hear people talking about their HIV status live. That made realise that being HIV infected it's not end of life.*

4.3.3 Theme 3: Adolescents' description of waiting times at the health facility

Generally, the findings showed that the waiting time was very important in reducing the participants' anxiety when they visited the clinic. They indicated that they are not made to wait for a long time at the adolescent clinic. Participant 3 *The waiting time is very acceptable at this clinic, as I take less than an hour, at times even half an hour. If I come wearing a school uniform, we are given first priority, so that we don't miss school classes.* Their waiting time differed, depending on the type of service each had come to access. Participant 2 reported that *the waiting time at this clinic is determined by what services I*

came to access that day. If I have come for a consultation, I don't take more than one hour. They reported that even if they had to spend some time waiting at the facility, they were kept busy with educational sessions, or they could also watch educational videos. The participants also indicated that during the school week, adolescents who wore school uniforms were given priority, so that they would be able to go to school. This meant that they would not miss school because of coming for health services.

According to the WHO (2012:26), in order for health services to be adolescent-friendly, the adolescents should not have to wait for long periods, and they should not have to wait in places where they could be seen by people by whom they do not want to be seen. Participant 5 confirmed the time conscious of the clinic by saying that *I spend less than two hours at this clinic. This is because in a day I have different appointed sessions. I could be coming for a treatment refill, or for a psychologist session. This was corroborated by* Participant 7 who further said that *I take a maximum time of two hours if I have to attend the peer-support group, as it is the longest session in this clinic. If I do not come for the peer-support group, I normally take less than two hours.*

Adolescents are very busy and impatient when it comes to waiting in long queues for services.

The following sub-themes emerged in relation to the adolescents' waiting times at the health care facility.

4.3.3.1 Sub-theme 3.1: Adolescents' conceptions of reasonable versus unreasonable waiting times

The participants indicated that the waiting time at the facility was very reasonable to them, and that it differed based on the type of care they had come to access. Participant 2 reiterated that by saying that *The time I spend at this clinic is very reasonable, as I only take less than an hour compared to other clinics where I used to take three to four hours.* Participant 2 was supported by Participant 8 who said that *I think the time I spend at this clinic is very reasonable, as I spend a maximum of two hours at this clinic. I think the way the service providers have designed the services improves the waiting time.* Some indicated that spending less than two hours at the facility was acceptable in order to be able to get all the services that addressed their needs. Others indicated that they wanted

to spend less than one hour at the facility. They confirmed that the service providers were really good at time management with their patients. They indicated that the services were well organised, and that the patients were guided towards the correct queues.

The participants also felt that the waiting times were reasonable because the services were provided during flexible hours, and this allowed the adolescents who attended school and worked to access the health services. The services were provided early in the morning, after hours, and also at weekends, and this also reduced the queues and waiting times, as additional operating hours and days to the normal clinic schedule were offered. The participants confirmed these findings in the following comments:

According to the National Health Strategy (Ministry of Health, Lesotho 2015:36) for adolescent-friendly health services, the hours of operation need to be flexible in order to accommodate both in-school and out-of-school adolescents. Participant 4 said that *the flexibility of the working days and hours has improved the waiting time, as the working hours are from 07:00 to 17:00, and they also open on weekends to provide treatment to those who are working and those who are at school.* The additional clinic hours benefit the adolescents and ensure that they do not wait for very long at the facility.

4.3.3.2 Sub-theme 3.2: Health education is provided through different media during waiting times

The findings indicated that the provision of health education was very important for everyone who came to the facility, as it helped to equip them with information on different health conditions, on the services available at the facility, and on how they could utilise the available services for their benefit. Participant 1 indicated that *during the health education, the service-providers give clear information on the services available at the clinic. This makes it easy to know where and how to get services that I have come to access.*

Health education was delivered through group sessions, through screening videos, and through the peer-support groups. Participant 8 said that *the education that is provided during the peer-support groups is based on real-life experiences, which makes them more understandable, as some of us are still going through all those challenges.* The participants indicated that the different media helped to ensure that those who did not

have the opportunity to participate in the group sessions still had the chance to learn from watching the videos or participating in the peer-support groups. Participant 6 *I enjoy watching television, as I understand better when I am watching and listening.*

According to Hutton and Jackson (2014:14), a lack of knowledge of health care services can be a major barrier to accessing health services for adolescents of all ages. Many adolescents do not know what primary health care services exist, or what those services are able to provide for them. Furthermore, they cannot seek out health services if they are unaware of the treatment options available to them.

The findings also showed that the adolescents came to the facility without knowing about HIV, or the importance of knowing their status, or the various support measures. Most of them had just thought it would be the end of their lives if they were diagnosed with HIV. Some indicated that they had learned about contraceptives and the different methods available to them, and that previously they had just thought that these were for adult patients only. Participant 7 said that *I thought contraceptives are for adult women only, but now I know that I have the right to get contraceptives. I now know how and where to get contraceptives.* Furthermore, they indicated that they had had the opportunity to learn about the sexuality and HIV, and to discuss some of the things that they were not able to discuss with their parents, due to cultural taboos. Participant 3 said that *The way the different conditions are being explained in simple language and with relevant examples, makes it easy for me to understand.*

According to Lung et al. (2017:S23), integrating reproductive health care services into an adolescent clinic is like promoting contraceptives and youth-friendly health services, in order to address the developmental needs of young people and the unique obstacles they face, and to promote greater access to and use of the health care services. The provision of health education helps to increase adolescents' awareness of the package of health care services available to them at the facility. Participant 3 said that *The information is so clear: why I should get tested, and the importance of knowing my status. This made it easy for me to take the decision to go for HIV testing.*

According to the WHO (2012:26), culture can deter adolescents from accessing certain health care services, as the social norms of many cultures strongly forbid premarital sex.

Participant 3 said that *This clinic helps me with information about sexuality and body changes, as my parents are not able to give me this important information.* This makes unmarried adolescents unlikely to seek care — even if they have a painful genital ulcer, or a possibly unwanted pregnancy. They are likely to try to deal with the problem themselves, or with the help of friends or siblings, whom they can trust to keep their secrets.

To ensure that no one around them comes to learn about their problem, they tend to turn to service-delivery points, such as pharmacies and clinics, that are at a safe distance from their homes, and to service providers who are willing to maintain their privacy. The availability of adolescent-friendly health care education provides an assurance to them that the adolescent clinic is a safe, private, and confidential place to share even their most sensitive health issues.

4.3.3.3 Sub-theme 3.3: Appreciation of apologies given for unreasonable waiting times

The findings indicated that there was always a youth ambassador stationed at the reception, who kept checking on whether the people in the queue had been helped. If people had not yet been helped, the youth ambassador would explain the reasons for the delay and would reassure them that they would soon be assisted. Participant 4 said *I appreciate the way the service providers always inform us if there will be delays in providing services to us, due to meetings, visitors, and any critical emergencies that they are attending to.*

This showed the patients that they were valued. Within a reasonable time, the doctor, nurse, or counsellor will arrive and explain why it had taken them so long to see their patients. The adolescents indicated that this showed respect from the service providers. They appreciated at least knowing exactly what was happening if there were delays. Participant 5 said that *There is always a person at reception, who is always looking on how the queue is moving, and that person is the one that will give us the message, if there are delays.*

According to the WHO (2012:5), adolescents are a heterogeneous group. The expectations and preferences of different groups of adolescents are understandably

different. It is interesting to note, however, that different groups of adolescents, from various parts of the world, identify two key, common characteristics: they want to be treated with respect and to be sure that their confidentiality is protected. Participant 7 said *I am young, but I think at the clinic the service providers still show respect to us by ensuring that they communicate to us in a respectful manner on anything that concerns our waiting time at the clinic.*

4.3.3.4 Sub-theme 3.4: The first-come, first-served principle and the handling of emergency situations

The findings showed that at the adolescent clinic, patients who arrives early were given priory. This means that the first person to arrive the clinic would always be the first patient attended to. However, the patients were made aware that even if they arrived early, there might be very critical patients or emergencies that would have to take precedence. In this case they would have to see an alternative service provider or wait until the emergency had been attended to. Furthermore, they indicated that students in school uniform were allowed to move to the front of the queue, so that they would be able to get to school on time and avoid missing classes or being absent.

The participants indicated that they did not have a problem with this, as it was made very transparent. There was a registration book that every patient had to sign on arrival, and this meant that patients could not cheat and jump the queue, as the registration book was always used as a reference for who had arrived first. This helped to minimise waiting times. These findings were confirmed by Participant 7 who said that *There is a lot of transparency when it comes to the lines, as we always register when we arrive at the clinic, and after the health education we still follow in the queue when going to access the health services.* Participant 1 agreed said that *There is no way people can manipulate the line, as there is always a person that ensures that the line is monitored, and this is really helping in minimising the time spent at the facility.*

4.3.4 Theme 4: Facts related to HIV counselling

The findings indicated that after the group counselling had been conducted through health education, each individual went to the counselling room for pre-test counselling. This is where adolescents had the opportunity to say whether they were ready for the HIV test or not. The pre-test counselling was a continuation of the group counselling, but the adolescents were given the opportunity to ask the questions that they had not felt comfortable to ask during the group counselling. Participant 6 said that *I was panicking when I heard them talking about HIV, as I have never been tested before for HIV. The health education helped me to calm down; and I was informed about the importance of knowing my status.*

The adolescent clinic used provider-initiated testing and counselling to ensure that all the adolescents were given the opportunity to know their status. Participant 9 revealed that *I am a very shy person, and during health education, I had a lot of questions to ask, but I could not ask them. Afterwards, the counsellor gave us the opportunity, like to go to the counselling room to continue the session, and to ask some of the questions that we felt we were not free to ask.*

This did not mean that those adolescents who voluntarily came to the facility for HIV testing were not given the chance to be tested. This was done to help the adolescents to make an informed decision to test for HIV, and to find out about all the support services that would be available for them based on their test results. Participant 3 reported that *Being sick and coming to the health facility, I was not thinking about HIV testing, but the information that I got during the health education caused me to make the decision to go for HIV testing.*

The adolescents showed that they felt empowered and supported to disclose their HIV status. According to Dawood (2015), services like HIV testing and counselling, with linkages to prevention, treatment and care, should be offered to all adolescents as a priority, especially those in the designated high-risk groups. As adolescents are being counselled, the importance of knowing one's status and the risks of HIV disclosure should always be part of the package of information given to adolescents. Adolescents should also be informed about the results of not testing for HIV, such as a late diagnosis and the complications associated with HIV infection.

4.3.4.1 Sub-theme 4.1: Pre-counselling leads to voluntary counselling and testing, acceptance of results and adherence to positive living

The findings showed that the pre-test counselling encouraged adolescents to make the decision to be tested for HIV. The participants indicated that they were afraid to be tested or to even enter the counselling room to take the HIV test. Participant 9 indicated the uneasiness by saying that *Entering the counselling room is not easy, I was so afraid of testing HIV positive.* However, the design of the patient flow at the adolescent clinic meant that after the group counselling, every patient who came to the adolescent clinic went through to the counselling room for the pre-test counselling.

The counsellor reviewed the patients' files periodically to ensure that those who did not know their HIV status went for pre-test counselling. Participant 7 explained the fears by saying that *I felt like I was being forced to test when they asked me to go to the counselling, because I felt like I was not ready after the health education. But after the pre-test counselling, I made the decision to go for the HIV test, as I was calmer and more informed about the testing and coping mechanisms, based on the results of the test.* The pre-test counselling provides the facts about HIV and helps to identify the risks that a patient might have been exposed to. Participant 6 said that *I felt like during health education I got enough information, but I learned that now during the pre-test counselling, everything is discussed in detail and every patient is individualised.* The participants indicated that the HIV diagnosis was a very frustrating moment. Some stated that when they entered the testing room, they were already thinking of the positive results, about how they were going to cope with the stigma and the discrimination from the community, and about how would they cope with the disease. Participant 4 revealed that by saying that *the challenge with me was that when going for testing, I did not imagine the positive results, but I already imagined how I am going to cope with the stigma and the discrimination. But the pre-test counselling helped me to see the results in two ways: both negatively and positively.*

An HIV diagnosis during adolescence coincides with all the other adolescent changes and creates sets of competing priorities. The pre-test counselling helped the adolescents to construct a view of life after the HIV test — no matter whether the results were positive or negative. This helped the adolescents to decide whether they were ready for HIV testing or not.

According Hosek et al. (2018:1), the HIV diagnosis can have a devastating effect on the lives of adolescents, as they have to adjust to living with a highly stigmatised health condition that will require daily medication and monitoring for the rest of their lives. An HIV diagnosis during adolescence occurs when they are already experiencing rapid changes biologically, cognitively, socially, and psychologically, and as they are traversing the developmental pathway and milestones associated with adolescence and emerging adulthood.

4.3.4.2 Sub-theme 4.2: Group health education leads to voluntary HIV testing

The findings indicated that for the health education, the participants were put into groups of 5–15 people. In these groups they discussed general information about HIV, to allow specific information to be discussed individually. Participant 3 echoed appreciation by saying that *the health education was very important, as it provided me with a lot of information with regard to HIV.*

This group discussion was utilised to reduce the amount of individual counselling time required. General issues that were discussed included HIV and AIDS, modes of transmission of HIV/TB/STIs, modes of prevention, ARTs, family planning, the meaning of HIV tests, and the benefits of testing. This laid a foundation for information about HIV and the importance of one knowing one's status. Participant 4 said that *When they educate about the risk for HIV infection, it is like introspection, as I already knew how many times I had been exposed to the risk, and this made me to decide to go for the HIV test.* Participant 2 concurred by saying that *the health education helped to allay my anxiety, as taking a decision for HIV testing is not an easy thing.*

According to Lesotho's HIV testing policy (Ministry of Health, Lesotho 2017:29), group counselling is used to shorten the lengthy individual pre-test counselling sessions. In this group counselling, health education is provided prior to individual sessions, in order to allow one-on-one sessions to be brief, focused, and specific to the individual's circumstances.

During this health education, options for referral to preventive services are also included, such as appropriate HIV-prevention services, VMMC, PrEP, condom use, family planning,

treatment as prevention, screening for TB and STIs, and screening for non-communicable diseases such as hypertension, diabetes mellitus, and cancers.

4.3.4.3 Sub-theme 4.3: Pre-test counselling prepares adolescents to take an HIV test

The findings indicated that after the group counselling, individual pre-test counselling was provided, which involved a one-to-one dialogue between the client and the counsellor. This is considered to be the most effective approach in pre-test counselling, where the risk exposure assessment, the feedback on individualised risk, and the exploration of individual risk-reduction plans can be conducted. The participants indicated that during this session they were able to go into detail about things that were specific to them and make their decision on whether to take an HIV test or not, depending on how ready they were. Participant 8 revealed that by saying that *During the health education, decision making for going for an HIV test was still affected by my peers. I listened to what they wanted to do, but in the pre-test counselling that was when I started to focus on my own life.*

Those who were ready for the HIV test gave their consent, and the counsellor took a blood sample for testing. Participant 4 indicated understanding by saying that *During this session, that's where the tester showed me the whole process of testing — how long the test is, and how simple it is to do the test. This made it easy for me to decide to do the test, based on how simple it is to do the procedure.* Those who were not ready for the HIV test were scheduled for further counselling sessions until they were ready for testing.

According to Lesotho's HIV testing policy (Ministry of Health, Lesotho 2017: 29), pre-test services should be offered to everyone before they are offered HIV testing. Pre-test counselling can be done through several pre-test activities, and these should take place before testing in all settings and with all target populations. The pre-test counselling services are designed to be one-on-one sessions that take place after the health education or group counselling, in order to focus on the individual's specific circumstances. Individual risk assessment should be carried out during the pre-test counselling.

4.3.4.4 Sub-theme 4.4: Post-test counselling is a learning opportunity on various aspects of HIV/AIDS

The findings indicated that the post-test counselling was usually guided by the outcome of the HIV test, which could be negative, positive, or indeterminate. Post-test counselling can take some time and gives way to ongoing support counselling. The post-test counselling was important because it reinforced and reviewed the information provided during pre-test counselling regarding risk reduction, the meaning of the test results, and disclosure issues. Participant 4 appreciated that by saying that *During the test, I was afraid, since I was expecting the results, but during the post-test counselling, this provided a good platform, from which I started to understand the meaning of my results.*

It also provided emotional, psychological, and physical support to help the participants cope with the results of the test, whether positive, negative, or indeterminate.

The counsellor facilitated an in-depth discussion on prevention issues, such as how the participant was going to prevent him or herself from getting re-infected or infecting others. Participant 1 said that *this is where the counsellor helped me to come up with my coping strategies, in order to help me to remain HIV negative forever. The counsellor also facilitated the referral plan to the prevention services*.

Lastly, the post-test counselling provided referral information for continued care and treatment, based on the individual's status.

According to Lesotho's HIV testing policy (Ministry of Health, Lesotho 2017:42), all clients, regardless of the outcome of their HIV test, should receive post-test counselling, based on their test results. Participant 2 confirmed by saying that *In this session, I learned that being HIV positive is not the end of life, based on the information I got and the emotional and psychological support. This gave me the courage and strength to continue living.* People who test HIV-negative should receive information about their test results that includes risk-reduction counselling, recommendations on the uptake of HIV preventive measures that include consistent and correct condom use, VMMC, and PrEP, where appropriate. A condom demonstration should be conducted by the HTS provider.

In sero-discordant relationships, counselling for those who test HIV-negative should include education on the best methods and behaviours to prevent HIV acquisition, such

as PrEP, and the use of male or female condoms, and lubricants. All clients who test negative should be encouraged to re-test, based on their HIV exposure risk. People who test HIV positive should receive information about their test results, and it is important to ensure that the HIV test results are correct. All post-test counselling should be conducted by the HTS providers, in a manner that is client-centred, responsive, and tailored to the unique situation of each individual or couple.

4.3.5 Theme 5: Description of services available for adolescents' health

The findings indicated that the adolescent clinic provided comprehensive health care services under one roof. This meant that all the health services provided at the adolescent clinic were integrated. Participant 5 revealed that by saying that *I always come to this clinic because I am attracted by the services when I am in this clinic, it's like I am in the supermarket to choose everything I want to buy. So, I am free to choose any service that I need.* Participant 5 continued to say that *The fact that when I am referred to other services I don't go to other places but I just change the room, and that makes my life easy, as going to introduce myself again to new people it's not easy to open up, as I have already built a trusting relationship.*

The services included out-patient or consultation services, HIV-testing services, linkage to care and treatment, risk assessment/prevention, repeat testing for at-risk adolescents, the provision of condoms, STI services, and active linkage to other services such as gender-based violence prevention programmes, post-clinical management, orphans and vulnerable children's programmes, pre-exposure and post-exposure prophylaxis, VMMC, behavioural counselling, and sexual reproductive health services, such as contraceptives, cervical cancer screening, and fertility awareness. Lastly, clients could be referred to the psychosocial services provided by the psychologist and the social worker, and there were also peer-support groups. It was shown that the provision of comprehensive health services to adolescents could attract adolescents to access those health services. Participant 4 summed it up by saying that *having different services provided at the same place makes me to come to the centre more frequently, and it is easy to access the services at this clinic.*

According to the WHO (2012:3), adolescent-friendly health services are aimed at preventing health problems or detecting and treating them. They often include the

provision of information, advice, and counselling. This is done through helping healthy adolescents to stay healthy, and by helping ill adolescents get back to good health.

This can be achieved through:

- The provision of information, advice, counselling, and clinical services aimed at promoting health and preventing health problems and problem behaviours
- The diagnosis, detection and management of health problems and problem behaviours
- Referral to other health and social service providers, when necessary.

Adolescents who are not feeling sick do not see the necessity of accessing health services, but adolescents who are sick readily seek health services. This means that comprehensive health services should be provided within the adolescent clinic, in order to ensure that prevention services are also available for adolescent who are not sick, and to encourage them to access health services.

According to the Namibia's national guidelines (Republic of Namibia Ministry of Health and Social Services 2012:3), HTS provide a critical entry point to care. This means that HTS should be integrated into all health services to ensure that HIV services are offered to all adolescents who come for different health services.

4.3.5.1 Sub-theme 5.1: Processes followed for referral to psychologists

The findings indicated that psychologists were always available at the adolescent clinic to screen adolescents for psychological factors. Those adolescents who tested HIV positive were referred to the psychologists. Some were in denial and some were suicidal. Participant 1 said that *there was a chain of services, to which I was referred, if I still remember well. After testing HIV positive, the counsellor referred me to the psychologist, and from there to the social worker, as I was in denial about accepting my HIV status.* The psychologist would counsel them in depth to ensure that they understood the importance of accepting their HIV-positive status. This would help the adolescents to learn how to cope with living with the infection. Participant 2 said that *I told the counsellor that I don't think I am ready to tell anyone about my HIV positive status, and the counsellor referred me to the psychologist, to help me on how to manage this problem, in order to*

get social support. The psychologists assessed the mental status of the adolescents and ensured that those who were at risk were referred to the mental clinic for further assessment and management. They would be able to receive continuous counselling, depending on their status and mental condition.

Adolescents who were already on ART after the first viral load test and who were not virologically suppressed were also referred to a psychologist to identify the psychological factors that prevented them from adhering to treatment. Participant 4 revealed that *I learned from the counselling room that I have a problem in managing peer pressure. After testing for HIV, the counsellor referred me to a psychologist, to help me with decision making to withstand any risky decision making influenced by peer pressure.* The psychologist would refer them to a social worker, who would assess them for social factors. The social worker could even conduct home visits to assess the whole family for family support, and to assess whether the adolescents had disclosed their status to their parents, spouse, and caregivers. Not all the adolescents who tested HIV negative were referred to a psychologist, but only those who the professional counsellor could see had some psychological factors that needed to be addressed.

According to Lesotho's HIV testing policy (Ministry of Health, Lesotho 2017:46), psychosocial support is an ongoing process of meeting emotional, social, mental, and physical needs. All these services are essential for meaningful and positive human development. Psychosocial support goes beyond simply meeting physical needs. It places great emphasis on psychological and emotional needs and the need for social interaction. It is very important that adolescents, after testing, are referred for psychosocial support, in order to improve their quality of health.

According to Hosek et al. (2018:1), a positive HIV diagnosis can have a devastating effect on adolescents, as they have to adjust to living with a highly stigmatised health condition that requires daily medication and monitoring for the rest of their lives. Some adolescents appear to be strong and cope well with a positive HIV diagnosis, but many adolescents lack the guidance and support of family, friends, and professionals to assist them in adjusting to their health condition.

All these problems create barriers, such as psychological distress, which has been associated with decreased adherence to medication, lack of social support, and an internalised stigma. These challenges are mostly felt in the first year after receiving an HIV diagnosis, as people struggle with the initial acceptance of their diagnosis, and with feelings of depression/isolation, fears of illness/physical symptoms, and anxiety regarding disclosure to others. Disclosure is a process, and it can either have positive or negative consequences. Some adolescents are afraid to lose their parents and friends after disclosing their HIV-positive status.

4.3.5.2 Sub-theme 5.2: Feedback processes on the services provided

The findings indicated that when adolescents arrived at the adolescent clinic in the morning, they were always informed on the services and told that they had a right to complain when they were not happy with the way the services were provided to them. Participant 6 said that *I like the way the adolescent clinic is allowing us to have input on things that we are not happy with.*

This could be in relation to the waiting time, the attitudes of the service providers, and whether they had received all the services that they had intended to get. The person working at the reception and registration area showed the patients where to get the forms to evaluate the adolescent clinic and how to put these in the suggestion box. Participant 5 reported that *I know that I am allowed to give feedback on the services that are provided to me, and to indicate whether I am satisfied, or not. They have the suggestion box that in the morning the person that talks to us informs us that we can write about anything with which we are not happy.* They indicated that the facility staff did review the comments that they made, and that their comments helped with the daily improvement of the services.

Complaints were addressed, and changes were evident at follow-up visits. This showed that the staff at the adolescent clinic tried to operate in the best interests of the adolescents, so that they would be more comfortable with accessing the health services. These findings were confirmed by Participant 7 by saying *Nothing for youth without youth. The adolescent clinic can only improve by listening to the people that are getting services from the clinic. I think one thing that helps this clinic to be the best is because the service providers are considering the suggestions that we provide, and always, as we come to the next visit I see the improvement.*

4.3.5.3 Sub-theme 5.3: Services were recommended to friends and relatives

The participants indicated that for the first time in their adolescence they were starting to enjoy accessing health services. They indicated that these services were accessible, affordable, and available. Participant 2 said that *I want my boyfriend to come to this clinic to gain knowledge of the services provided, and I think they could be very helpful to him.* The participants indicated that because the adolescent clinic was located in town, and in the centre of town, it was easy to access. There was also an information board that showed the location of the clinic, the services that were provided, and the operating hours. Participant 1 emphasised the accessibility of the clinic by saying that *I can recommend the services to my friends, as the clinic is easily accessible, and some of the services are free, and it is easy to direct someone where to get the clinic, as it has a signage board with a list of the services that are being provided.*

The clinic operated for six days a week, from Monday to Saturday, and was open from 7.00 am to 5.00 pm from Monday to Friday, and from 8.00 am to 1.00 pm on Saturday. Participant 8 echoed the satisfaction by saying that *The flexibility of operating hours and days makes this centre the best, and I tell my friends about the clinic and the services provided, so it is up to them whether they come or not, as I cannot force them.*
This meant that adolescents were able to access services at convenient times. Those who were not in school and were not working could access the health services during the course of the week, while those who were in school or working were able to access health services in the early morning, in the afternoon, or over weekends.
They also indicated that all the services are free, except for a R15 consultation fee. These services included HIV testing, contraception, antiretroviral treatment, counselling sessions, peer-support groups, viral-load monitoring, prevention of mother-to-child transmission (PMTCT) services, STI services, couples counselling, premarital counselling, and sexual and reproductive health services. The participants indicated that these services were available all the time, and were provided by young people who were never judgemental.

The participants indicated that they received the services that met their needs as adolescents. They therefore recommended the services to their peers, friends, and family

members, so that they too could access health services that would help them to remain healthy. Participant 4 concurred by saying that *Yes, I can recommend the service to my buddies, as I know the problems that I have been going through with them, since they have also experienced them — so they need to come and get some help.* The adolescents who accessed the health services at the clinic acted as champions for the clinic and created a demand for the services. Participant 7 supported participant 4 by saying that *Yes, I want my friend to come and access the health services. My friend has never been tested for HIV, and she is afraid to test. I think the knowledge dissemination that is being provided at this clinic could help her to gain the necessary confidence to test for HIV.* Their enthusiasm was based purely on the quality of the health care services they received at the clinic. Participants who were HIV infected and were already on ART indicated that they never felt stigmatised or discriminated against, since all the services were provided under one roof, and the nature of their visit was therefore always confidential.

According to the WHO (2012:7), if health care services are friendly, then adolescents are more likely to be able and willing to obtain the health services they need. Service providers should therefore ensure that the health services that adolescents need to stay healthy, or to return to good health, are in fact being provided, and are being provided in the right manner. This would encourage adolescents to inform their friends and family members to also come and get help.

4.3.5.4 Sub-theme 5.4: Health education leads to understanding disease processes and adherence to treatment

Some of the participants indicated that when they first came to the facility, they had little knowledge about health and disease, and believed myths that were spread by their peers. Participant 3 said that *Before I came to the clinic, I had a lot of myths about HIV transmission, and what people infected by HIV look like. I was shocked to see a very beautiful girl publicly speaking about HIV and telling us how important adherence to the treatment is for the quality of life.*

However, some had detailed information, as it was not the first time they had visited the facility. After the participants registered at the clinic, they were provided with health education in the waiting room by the youth ambassadors. This health education covered

different topics, which were suggested by the youth ambassadors and the adolescents themselves. Health education was the first service that was provided to the adolescents, as a way of preparing them for HIV testing and for accessing other health services. The way in which the health education was delivered created a relaxed atmosphere that encouraged the adolescents to communicate freely. The health education was specifically for adolescents and provided them with opportunities to ask sensitive questions. Those adolescents who did not feel free to ask questions during the health education were given the chance to ask them in the counselling room, where they only had to speak to the service provider. Participant 3 revealed that *During the health education, I was afraid to ask some questions; as they were more personal. I was happy when they gave us the chance to ask such questions in the counselling room. I think the health education lays the foundation for the testing for HIV.*

The adolescents were also given the opportunity to give their own testimonies about their journey of living with HIV. They shared the challenges they had faced, and how they had overcome these challenges, and what messages they took home for their peers, who also might be diagnosed HIV positive. This really worked for the adolescents, as they started to see that their test results would not change who they were but might help them to start a new chapter of life. Participant 4 *Adolescents living with HIV, talking about their HIV status to us really inspired us to be brave enough to test for HIV, and to be ready to accept any type of results.*

If they had tested HIV negative, they were equipped with the necessary prevention services to help them remain negative. Those who tested positive were started on treatment immediately, in order to stop the replication of the virus and to allow the immune system to recover and be virologically suppressed. They understood the coping strategies that would help them to fight the stigma of HIV and any discrimination that would come from their parents, their community, their friends, and their school.

Adherence is a major challenge among adolescents living with HIV in low- and middle income countries (Ridgeway et al 2018). This means that education and counselling for adolescents should be strengthened, in order to ensure an improvement in their treatment outcomes. Scaling up the differentiated care models for adolescents can result in improvements of their viral load. Furthermore, expanding HIV testing efforts in many low- and middle-income countries, and establishing new test-and-treat or test-and-start

programmes, has improved the number of patients diagnosed with HIV. They immediately they become eligible for treatment, challenging providers to ensure high adherence among a larger, healthier patient population (Ridgeway et al. 2018:1–33).

4.3.5.5 Sub-theme 5.5: Description of ethical standards adhered to during care

The findings indicated that after the health education, adolescents could voluntarily go to the counselling room for the HIV test. This meant that the adolescents were given voluntary testing for HIV. They were not forced to go for an HIV test, but gave their consent. In the counselling room they received one-on-one counselling in a private and safe place. The counsellor assured the adolescent of the confidentiality of the counselling, making it easy to follow up and refer the patient for continued care. The counsellor provided pre-test counselling, which assessed the adolescent's risk for HIV, and provided information on the test and the meaning of the result, negative or positive.

After the pre-test counselling, the participants were given the opportunity to decide whether they would like to go ahead with the HIV test, and whether the counsellor could obtain the adolescent's consent to be tested. Participant 5 participant confirmed that *I was not forced to be tested, I am the one who gave the counsellor the go-ahead to test me. I felt ready to test, as I had enough knowledge about HIV.* Participant 3 supported by saying that *I was a bit undecided about whether to test after the health education, but the pre-test counselling, this helped me to make an informed decision to test.* After the test, the results were interpreted by the adolescent and the counsellor, to ensure that the results were correct, based on the guiding steps for the HIV test as Participant 1 confirmed by saying that *I was the one reading my results, to ensure that I have the correct results, as the counsellor before testing explained the process of testing to me.* After the results had been interpreted, the counsellor provided post-test counselling, which was based on the results of the HIV test. The counsellor then referred those tested HIV positive to the applicable services, including psychosocial services, while those who tested HIV negative were referred to the prevention services, in order to help them to remain HIV negative. These findings were confirmed by Participant 7 who said that: *I think I like the confidentiality issue, whereby everything is kept confidential and shared confidentiality when I was referred to the nurse for treatment. The nurse was not judgemental, but she just continued from where the counsellor had stopped.*

According to the Lesotho's HIV testing policy (Ministry of Health, Lesotho 2017:8), service providers should adhere to public health and human rights when providing HTS. Service providers should ensure that the principles of counselling are followed (consent, confidentiality counselling, correct results, and connection) as the foundation for effective HTS.

Consent: The patient who receives testing must consent to be tested and counselled. This means that adolescents should be informed of the process of HIV testing and of their right to decline such testing.

Confidentiality: Anything discussed between the counsellor and the patient should not be disclosed to anyone, without the consent of the person being tested. Shared confidentiality with a partner, or family members, or trusted others and other service providers is encouraged.

Counselling: After group counselling is conducted in the form of health education, one-on-one counselling should be conducted in a private setting to answer questions the individuals may have that they do not wish to share with others. HIV testing must be followed by the appropriate high-quality post-test counselling. Counselling during HIV testing among children must be accompanied by correct pre- and post-test counselling conducted by an appropriately trained person. This provision ensures that children and their caregivers make the appropriate choices regarding HIV testing. No person may disclose a child's HIV status without consent.
Correct: Quality-assurance mechanisms are essential to ensure that people receive the correct diagnosis.

Connection: Based on the patient's results, they should be linked to prevention, treatment, and care services, and effective and appropriate follow-ups should be conducted.

4.3.6 Theme 6: Challenges faced by adolescents in relation to their HIV-positive status

The findings indicated that being diagnosed HIV positive during adolescence is not easy to cope with. The participants indicated that they feared the stigma of HIV, and discrimination from their community, parents, and friends. Participant 2 echoed the fears by saying that *the main challenge with being tested HIV positive is that one never decides to be HIV positive but has to face a community and society that stigmatises and discriminate against people living with HIV, and the worst part is now still being an adolescent.* They also faced the challenges of taking treatment for life and coming for regular check-ups every time they collected their medication. Some participants indicated that they were rejected by their parents as a result of being HIV positive, as their parents did not want to be associated with the disease. Adherence is also a major challenge, as they have to take medication every day, and for the rest of their lives. Participant 1 said that *Imagine being diagnosed HIV positive at the adolescent stage and being told then that the treatment is for a lifetime. Now, to integrate treatment and the time to take treatment into a busy schedule for the adolescent stage it is not easy at all.* This is not easy, as adolescents have a very busy schedule, and some are still at school. Some were rejected by their partners and had therefore lost a loved one. These findings were confirmed by Participant 7 who voiced the dissatisfaction by saying that *testing HIV positive is not easy at all, even if someone is equipped with information and assured of all the support services. The challenge is that after testing, they are immediately expected to take treatment, and are then told that the treatment is for a lifetime. Yooooh!*

According to Ridgeway et al. (2018:1–33), adherence is a major challenge among adolescents living with HIV. Expanded HIV testing efforts and new test-and-treat or test and-start programmes have increased the number of patients diagnosed with HIV, and who are immediately eligible for treatment. This challenges service providers to ensure high adherence among a larger, probably healthier patient population. It is very important that a lot of interventions are put in place, in order to improve the adherence for adolescents now living with HIV.

These findings helped to understand the psychosocial experiences of the first generation of young individuals who acquired HIV through vertical transmission, through reports of their life stories and obstacles faced in the context of living with a chronic disease, in order to prepare health professionals to better care for their patients. In the several dimensions of daily life, such as participation in social activities, school, and work, the participants

referred to a normal life, that is, common or equal to those of other young individuals who are not infected.

Lesotho is running a test-and-treat programme for all patients diagnosed HIV positive, so that they can still feel normal. The perception of normality, and the feeling of being of equal status, are justified by the absence of symptoms or physical characteristics of a diseased body; but these factors, in turn, can negatively influence the habit of treatment adherence.

Regarding health care and treatment, the participants indicated that adherence to the medication regime was a dynamic process, and involved subjective and objective dimensions, and moments of greater or lesser interest in relation to clinical monitoring. Despite their weariness regarding the medication, and their desire to sometimes discontinue the treatment, most of the adolescents showed that they were aware that to maintain a good quality of life, adherence was very important.

They indicated that their correct and consistent use of ARVs for good adherence was informed by their belief in the medication's efficacy, and by the fact that health care had become a priority in their lives. Their acceptance of their HIV status, and the acknowledgment of death that comes with maturity, were also decisive factors in their maintaining adequate treatment. A good connection between the adolescents and the health care professionals and family support provided the necessary motivation to face the health and disease processes.

However, some of the adolescents indicated that they did not like to feel pressured, and that they considered the overbearing attitudes of their caregivers to be a violation of their personal rights and their autonomy to make their own decisions on the treatment. The participants also mentioned the adverse effects of the drugs and their interference in one's daily activities as barriers to full adherence. In the subjective dimension, moments of sadness and stress, and the simple desire to live life without constant reminders of the virus, justified for them any interruptions, even if brief, of the treatment.

These points are expanded upon in the sub-themes below.

4.3.6.1 Sub-theme 6.1: Rejection by sexual partners

The findings indicated that some of the participants were rejected by their partners after being diagnosed HIV positive. After their diagnosis, the adolescents were counselled on the importance of index testing. This is where they were asked about whether their partners knew their own status, and whether they had biological children together. Furthermore, they were encouraged to disclose their status to their loved ones — their parents, their friends, and boyfriends. Participant 1 raised her fears by saying that *after testing HIV positive and initiating treatment, I am expected to come for a check-up after 14 days, and then from there every month for six months. The main challenge is now I am forced to tell my parents about my status, as they have to give me transport money to collect my medication and for my check-ups.*
Some were forced to disclose their status to their parents, as they had to ask for transport money from them every month in order to come for a treatment check-up and ART refill.

When it comes to matters of sexuality and romantic relationships, in addition to the challenge of disclosing one's HIV status to a sexual partner, there are legitimate strong concerns about transmission of the virus to the partner. Participant 2 raised her confusion in terms of disclosing to the partner by saying *being tested HIV positive confused me, because during the pre-education and pre-test counselling, it became clear, and it forced me to reach the decision to test. I will be thinking that I am ready to even face the results and cope. But after testing positive, it's like starting from the beginning — especially when looking at how I am going to cope with the sexuality issues. Will my boyfriend still accept me if he finds out that I am HIV positive? And will I still be able to have children?* Still in the context of romantic relationships, desires and anxieties caused by the HIV status are mixed up and, sometimes, avoidance behaviours prevail. These findings were confirmed by the participants as follows:

These findings are in accordance with Hosek et al's (2018:1) findings on the particular difficulties of an HIV-positive diagnosis for adolescents, as discussed under sub-theme 4.1 and sub-theme 5.1. These difficulties can create psychological distress and barriers to adherence to medication. They are felt most acutely during the first year after diagnosis, which is a significant period of acceptance and adjustment. Disclosure is a sensitive process that can produce either positive or negative consequences, and adolescents are

often afraid of the possibility of losing their support network of family and friends, at a time when they are usually not yet self-sufficient, emotionally or economically.

4.3.6.2 Sub-theme 6.2: Feelings of depression, despair, and suicide

The findings also indicated that after being diagnosed HIV positive, some of the participants became very depressed and some started to feel suicidal. They indicated that they felt hopeless, and as if it was the end of their life. It was difficult for them to face their parents, friends, and community. Participant 7 said that *I didn't know how I was going to face my parents, especially my father, who always named people living with HIV as prostitutes and all bad names. Now, being his child and being HIV positive, it was very difficult for me, and I felt like there is no need for me to continue living.*

Experiencing the stigma of HIV infection and acts of discrimination from their families and communit0ies made matters worse and led some of them to feel that the better option would be death. Some adolescents who tested HIV positive indicated that at the adolescent clinic they never felt rejected or neglected, as the service providers supported them. Participant 1 revealed a different situation as she said that *I tested with my boyfriend and he tested HIV negative and I tested positive. I was very depressed and felt like I should commit suicide, as he already showed rejection after we got the results. I loved him with all my heart; and I already saw that I was going to lose him.* The counsellor provided them with counselling and they were also referred to the psychologist for mental health assessments, psychological support, and counselling. They were also referred to the social worker to assess the social factors that might affect their adherence to treatment as Participant 9 indicated that *Living with the secret of being HIV positive, on the other hand, is not an easy thing. Taking treatment secretly and going for check-ups without one's parents knowing is also a challenge, since at times it affected my adherence to treatment. This caused me to be always stressed.*

The researcher observed feelings of ambivalence when the adolescents were faced with the need to undergo care that involved an endless treatment and routine of medical consultations. Some of them faced the challenge of living with the secret of their diagnosis and with the possibility of transmitting the virus. An important issue that deserves special attention concerned the dynamics of the secrecy surrounding adolescents infected by HIV/AIDS. Their disclosure of their diagnosis to others was not a simple process, because

revealing their HIV status had the potential to make them vulnerable to social stigma, prejudice and discrimination, aspects that are widely identified in the adult population living with HIV/AIDS. The anxiety about disclosure was particularly acute in relation to their families, whom they lived with and relied on. From the point of view of the participants, their secrecy was justified by their fear of prejudice, rejection, and social isolation. These findings were confirmed by the participants as follows:

According to Lightfoot et al. (2017:2), adolescents who are tested for HIV often encounter health care service providers who are judgmental, because they are not trained in adolescent-friendly health care services. Their parents, caregivers, and families can also affect adolescents' decision to test, since the identification of an adolescent's HIV-positive status can represent the potential exposure of the parent's positive HIV status. Furthermore, parents' fear of the HIV stigma and the probable adverse consequences causes them to worry about their adolescent's emotional reaction. The desire to protect their children can paradoxically result in a lack of parental support and a refusal to provide consent for HIV testing for children younger than 18. Some parents often perceive adolescents as being at lower risk for HIV, and cultural taboos can undermine conversations with adolescents about sex and HIV risk.

4.3.6.3 Sub-theme 6.3: Self-blame and shame experienced after the initial diagnosis

The findings indicated that risk assessments were conducted during the pre-test counselling, during which each individual was asked to try to remember and list all of their risk behaviours.

After considering these questions, and then being diagnosed HIV positive, people often start to blame and judge themselves for not being careful enough. Some indicated that they had transactional sex with various partners based on their practical needs. They would have a sex partner with a car that would be able to transport them wherever they needed to go. They would also have partners that would be able to provide them with cash, and cell phones or airtime. These partners, in most cases, were older working men. Once they had provided the things that the adolescent girls needed, the transaction was finalised with the exchange of sex, and at times unprotected sex. Some of the participants deeply regretted their decisions, and the fact that they had not been strong enough to withstand peer pressure and resist the risky behaviours that put them in danger. These findings were confirmed by Participant 2 who said that *After I tested HIV positive, I hated*

myself, as I felt that it was all my fault, because I was careless by not taking the responsibility of protecting myself.

According to the Lesotho HIV testing policy (Ministry of Health, Lesotho 2017:10), HIV testing is the gateway to HIV prevention, treatment, care, and support services. Access to HIV testing is important so that every Mosotho has knowledge of his or her HIV status. The following are considered to be the key drivers of the epidemic in the country. These key drivers mostly affect adolescents and put adolescents at a greater risk of HIV infection.

- **Early sexual debut**: The age of sexual debut in Lesotho is low (around 15 years) with the average age at marriage being 25 years.
- **Multiple concurrent sexual partnerships**: Having multiple sex partners is very common in Lesotho, and increases the risk of HIV transmission, especially when combined with unsafe sex.
- **Gender inequality and gender-based violence** are fuelled by the low socioeconomic and legal positions of women when they are not empowered to take decisions regarding their lives. This predisposes them to sexual abuse, together with the violation of their rights and risk of HIV transmission.
- **Intergenerational sex**, especially between older males and younger females, is due to the socio-economic vulnerability of young people, particularly girls, who get involved in transactional sex, and thereby increase their exposure to HIV.
- **Poverty (income inequality)**: The available evidence indicates that it is not poverty that necessarily drives the epidemic, but rather income inequalities that cause people to engage in transactional sex more frequently.
- **Alcohol and drug abuse**: HIV and AIDS are both linked to alcohol and drug abuse problems, which contribute to the increased spread of HIV, due to impaired judgement.
- **Low condom use**: The 2014 Lesotho Demographic Health Survey (LDHS) indicates that there is low condom use: 65.3% of men and 53.9% of women aged 15–49 years with multiple sexual partners do not use condoms during high-risk sex (Ministry of Health [Lesotho] & ICF International 2016).
- **High levels of unprotected sex** expose individuals to the risk of sexually STIs and HIV transmission.

4.6 SUMMARY OF THE CHAPTER

This chapter has presented and discusses the research findings from the individual, semi-structured, in-depth interviews conducted with nine adolescents who accessed the health services at the Public Hospital adolescent clinic. The findings were described and presented in a narrative format. Verbatim excerpts from the participants were presented to support the findings, which were integrated with the relevant literature. The findings were structured according to six primary themes that emerged during the data analysis, each of which had a number of sub-themes. The following final chapter will summarise the study, and present the overall findings and recommendations.

CHAPTER 5

FINDINGS AND RECOMMENDATIONS

5.1 INTRODUCTION

Chapter One provided an introduction and general orientation to the research report, and focused on formulating and framing the research problem by outlining the background to the research, defining key concepts, and presenting the research purpose, the objectives of the study, and the research questions. The research methodology used in the study was presented by describing the qualitative, exploratory research design, the population and the purposive sampling, the semi-structured interviews conducted to generate data, and the thematic analysis used to analyse the data, based on Colaizzi's (1978) sevens step process. The measures that were taken to strengthen the trustworthiness of the study, and ethical considerations that the research took into account, were also discussed.

Chapter Two reviewed literature on the importance of adolescent-friendly health care services, in the particular context of the HIV pandemic. The review focused on adolescents and HIV, HIV services and adolescents, adolescent-friendly health services, best practice for HIV service to adolescents, and the challenges of HIV testing for adolescents.

Chapter Three described the research methods used for this study The rationale for using a qualitative approach and an exploratory design was explained, after which the processes of participant sampling, and data collection, analysis and verification were explained. The ethical considerations taken into account during the course of the study were also described.

Chapter Four presented and discusses the research findings from the individual, semi-structured, in-depth interviews conducted with nine adolescents who accessed the health services at the Public Hospital adolescent clinic. The findings were structured according to six primary themes that emerged during the data analysis, each of which had a number of sub-themes.

This final chapter presents the end product of the researcher's endeavours. After recapping the rationale for the study and the central issues that prompted the researcher to undertake the study, a broad overview of the main findings will be presented in detail, in relation to the research objectives presented in Chapter One. This will subsequently be linked to recommendations, as well as to the limitations of the study. An overall conclusion will then be drawn, revealing the perceptions of the adolescents on the use of the HIV youth-friendly centre.

5.2 RATIONALE AND CONTEXT

The preliminary literature review undertaken by the researcher showed that HIV testing services for adolescents are affected by particular factors. Lesotho's Ministry of Health is doing its best to promote HIV services to the general population after implementing the test-and-treat programme in June 2016. However, there are a number of specific issues that need to be considered to ensure that adolescents receive quality HIV health care services.

The purpose of this study was therefore to gain an understanding of adolescents' perceptions on the use of the HIV youth-friendly centre at Public Hospital in Maseru, Lesotho. In order to achieve this purpose, the following objectives were formulated:

- To explore and describe the perceptions of adolescents on the use of youth friendly services.

- To identify the best practices that could be recommended to the health care authorities, in order to scale up youth-friendly services.

These objectives translated into the following research questions:

1. What are the perceptions of adolescents on the use of the youth-friendly services?
2. What recommendations could be made to health care authorities regarding the use of the youth-friendly services by the adolescents?

5.3 THE MAIN FINDINGS

5.3.1 Adolescent Friendly environment at the health facility

The participants generally felt that having a dedicated, private space where they could access health care services — without having to mix with adult patients, and possibly having neighbours and relatives observe them — put them at ease and made them more comfortable with accessing the services. The participants indicated that prior to the dedicated adolescent section, it had been difficult for them to access services confidentially, and they would sometimes leave without seeing the clinician in order to avoid having to explain themselves to community members, relatives, or friends of their parents. Their parents were usually unaware that they had visited the clinic to access health services. From the stories shared by the participants, the researcher concluded that the adolescent corner was a very emotionally secure environment for adolescents to access their health services in a confidential and private space.

5.3.2 Different health services leading to uptake of HIV services

The stories shared by the participants indicated that the services available to them at the adolescent clinic were necessary and very helpful. They appreciated being able to access multiple health care services at one site, which helped them to maintain their privacy and confidentiality. They also appreciated being able to consult with the same service providers with whom they had already built a rapport, and with whom they had established

a trust relationship. The researcher concluded that the provision of comprehensive services at the adolescent corner was very helpful and important, as it saved adolescents from having to go to different entry points and consult with different service providers whom they had not met before. They did not have to repeat the same emotionally sensitive and potentially embarrassing information to multiple service providers at different sites. At the adolescent corner they shared their stories with one service provider, after which all the appropriate services were provided to them. This also saved them time, as they did not have to join different queues, and did not have long waiting times.

5.3.3 Description of the reception experienced at the health facility

According to the participants, the system for the patient flow at the clinic was clearly communicated, which was very helpful for first-time visitors, who are sometimes too shy to ask for guidance. The participants further indicated that they appreciated the presence and the availability of the youth ambassadors, who were there to provide guidance to all the adolescents who had come to access the health services. These youth ambassadors directed them towards the appropriate services and queues. The participants also indicated that the clear patient flow helped them to avoid missing some of the services that were very important to them, since they did not know about these services before they came to the clinic. Based on the participants' responses, the researcher concluded that the adolescents were very happy that the patient flow was designed to ensure the smooth transition of patients between different service points.

5.3.4 Existing Methods of care to address the adolescent's needs

The participants indicated that the services provided at the adolescent corner and the operating hours were clearly displayed on an information board for everyone to see. If they read the information board, they would come to the adolescent corner well prepared for those services, and would not waste their time trying to access services that were not indicated. The information board also helped to alert people to the services available for them to access. From the stories shared by the participants, the researcher concluded that it is very important to have an information board at adolescent-friendly clinics, to ensure that visitors are well informed about the services that are provided and the

operating hours, and are therefore well orientated for their visit. This could also help to attract more people to the clinic by alerting them to the available services.

5.3.5 Non-judgemental attitudes of health care professionals and adolescent's self-worth

The findings showed that service providers at adolescent-friendly clinics need to assume a professional role and practise professional values, instead of a parental role with parental values. If they are open, approachable and, most importantly, non-judgemental, adolescent patients are more at ease and relaxed, and feel more comfortable to freely access a range of services, particularly those that are very sensitive for a young person to discuss with an older person. The participants indicated that they appreciated being respected. During some of their other health care experiences they had been treated as if they did not exist, or even shouted at. They indicated that such treatment intimidated them and raised their anxiety, preventing them from opening up to the service providers who were entrusted to help them. From the stories shared by the participants, the researcher concluded that service providers should be aware of their attitudes. They should strive to be non-judgemental, and should treat the adolescents with sensitivity and respect when they come for their health services.

5.3.6 Adolescent conceptions of reasonable versus unreasonable waiting time

The adolescent participants indicated that they do not like having to wait in long queues when they come to access health services. Adolescents are a very busy population, and are therefore very impatient, so having short queues at the clinic was an advantage for them. They were able to access the necessary services without compromising their school day or their work day. According to the participants, the short queues enhanced the privacy of the services, as long queues would have exposed them to the curiosity of multiple people over a long period of time. Short queues also reduced their emotional frustration and stress, which was significant, as many of the health services they had come to access were related to potentially sensitive and stressful conditions. Short queues made the services more enjoyable and more accessible, as the adolescents could come at times that were convenient to them, unlike in other facilities, where late arrivals are sent away due to long queues.

From the stories shared by the participants, the researcher concluded that the short queues at the health facility made the services more easily accessible to the adolescent clients. Furthermore, short queues are also good for people who do not want to be seen by a lot of people when they have come to access sensitive and potentially embarrassing health care services. Short queues reduced stress and promoted the privacy of the patients and made the facility more adolescent-friendlier.

5.3.7 Feedback process on the services provided

The idea of “nothing for youth without youth” emerged from many of the participants in their answers to different questions. The participants indicated that at times the service providers had brought unsolicited services to them, and had pressured them to use those services, even though they were not interested. HIV testing was an example of where some of the participants felt pressured. However, as part of the service offering, the adolescents were encouraged to evaluate the services, and provide advice and input on how they felt the services should be administered to them. They were also encouraged to indicate what services they needed, and how they should be packaged.

The participants also indicated that the presence of young people (the youth ambassadors) at the facility as service providers was of critical importance for them, and made all the difference. They shared the same characteristics, needs, and challenges; they had shared similar experiences; and they spoke the same language, which eased difficult discussions considerably.

From the participants’ stories the researcher concluded that there should be meaningful involvement of young people in the planning, design, and implementation of adolescent friendly health care services, and that they should have a meaningful role and physical presence at the facility. There should also be opportunities for adolescent clients to provide feedback on the services they receive from the facility — on whether they want those existing services, or whether they want them to be changed or repackaged according to how they need them to function from the user perspective.

5.3.8 The processes followed for referrals to psychologist

The need to be supported by psychologists and social workers was strongly emphasised by the participants. They indicated that it had not been easy to accept and cope with their HIV-positive diagnosis, but that their sessions with the social workers and the psychologists had been extremely helpful, as they had instilled in them a sense of hope and courage. They indicated that these sessions had helped them to be able to understand how to live with the disease, and how to address some of the social and psychological issues that could interfere with their adherence to treatment. However, the participants indicated that at certain times, when they had really needed to see the psychologist or social worker, they had not been available, as they also consulted with patients from nearby facilities. This meant that they had to make another appointment with them, which necessitated having to make an extra trip to the facility. From the participants' stories, the researcher concluded that there is a need for psychological and social support for adolescents — both those who are HIV positive and those who are HIV negative — in order to help them to navigate the developmental challenges of adolescence alongside the physical and emotional challenges of living with HIV, or living to successfully prevent HIV. Psychosocial support will also enable HIV-positive adolescents to prepare themselves to deal with the societal challenges they may face, and to make informed decisions about their new life.

5.3.9 Health education leads to understanding the disease processes and adherence to treatment

The participants indicated that they enjoyed the way in which the health education was delivered. What they liked most was that the health education was delivered by young people, which put them at ease to communicate freely and ask questions. It was communicated in youth language that was easy to understand, and the young facilitators were very relatable and had shared similar experiences to them. The participants indicated that the service providers emphasised the importance of everyone attending the health education. They felt that it was worthwhile, however, and stated that the sessions helped them to relax and start to build a rapport with the service providers, and also gave them a clear picture of the services that were available for them at the facility. The participants further indicated that the health education sessions addressed dangerous

myths and equipped them with the correct information, and allowed them to ask questions about things that had been bothering them for a long time. Most importantly, however, the health education group sessions served as an effective doorway HIV testing, as it helped the participants to feel informed and comfortable enough to get tested.

From the stories of the participants, the researcher concluded that it is vital that health education be offered at adolescent-friendly clinics, in order to provide adolescents with an overview of the service package at the facility, and to encourage and challenge them to know their HIV status. Group sessions can assist adolescents to make the decision to be tested, as they are able to ask questions, address myths and misconceptions, and receive peer support and encouragement.

5.3.10 Success stories related to disclosure of HIV+ status shared amongst the youth at the facility

The participants indicated that they were initially amazed to hear people talking publicly about their HIV status, as this was something that was not common with young people. The youth ambassadors at times talked about their experiences of being HIV positive and taking treatment. This addressed the myth that HIV-positive people look like ghosts and are emaciated, and made the participants less fearful about knowing their own status. The openness of the youth ambassadors encouraged other people who were living with HIV to open up about their status. This was extremely reassuring for those had not yet been tested. They were able to relax a little and see that one can be HIV-positive and still live a normal life and continue to achieve one's dreams. They did not have to define the disease purely in terms of stigma and discrimination but could to start to imagine living with HIV more positively.

From the stories shared by the participants, the researcher concluded that in adolescent friendly clinics peer-to-peer counselling, or empowerment, where young people are present as positive role models for patients, is vitally important. It is important for the decision-making process in relation to HIV testing that adolescents hear positive stories of how other young people who are just like them have constructively dealt with the challenges of being HIV positive. This empowers and reassures young people that they

too will be able to cope if they test positive. If they test negative, it also motivates them to engage in all possible preventative measures to remain HIV negative forever.

5.3.11 Organised management of adolescent's care experience

The participants indicated that the services were provided according to flexible hours and days. This flexibility was extremely important to them. Some were still in school, some had jobs, and some had not disclosed to their parents that they needed to come to the facility. They therefore needed to visit the facility when they could, at times that were convenient for them. Those at school preferred the early morning hours and the weekends, to avoid missing school. From the stories of the participants, the researcher concluded that it is important for adolescent-friendly facilities to operate within flexible, extended hours to accommodate those who are not able to come during normal working hours and on weekdays.

5.3.12 Description of ethical standards adhered during the care

The participants indicated that the fact that their confidentiality was assured by the service providers helped to ease their anxiety, and therefore their resistance to diagnosis and treatment, as they did not want to be labelled or judged by their medical condition or defined by their diagnosis. They indicated that a full explanation of the shared confidentiality among service providers also helped, as it helped them to understood that shared contextual knowledge among the service providers enhanced their continued care as patients. The participants also appreciated having their rights respected and being given the opportunity to make their own decisions before giving consent for examinations and procedures, and not being forced. From the stories of the participants, the researcher concluded that ethical standards are very important in adolescent-friendly clinics, especially when they are practised to ensure that adolescents are served appropriately. Adolescents appreciate being treated with respect and not being forced, and they value privacy and confidentiality.

5.3.13 Existing motivational counselling geared towards health decision-making by adolescents

The participants indicated that having peer support groups was very helpful for reinforcing life skills through discussion. The groups helped to develop their self-awareness, so that they could understand who they are, their values, their needs, and their desires. They also stimulated critical thinking, to improve the adolescents' decision-making skills and their ability to solve their problems. Lastly, the peer-support groups helped them to develop their emotional communication skills, so that they could express themselves confidently, access information, meet their needs, and prepare for the future and their transitions in life.

From the participant's stories, the researcher concluded that peer-support groups in adolescent-friendly clinics play a very important role in ensuring that the clinic operates according to the test-and-treat guidelines. The test-and-treat programme makes ART accessible to all, and it incorporates life skills and encourages self-motivation for treatment and adherence. Furthermore, the peer-support groups support the acute to chronic disease management of young people living with HIV, in terms of testing and ongoing monitoring of viral load, supporting disclosure, and supplementing support from parents, teachers, and partners. Lastly, peer-support groups prepare adolescents for the transition to independent adulthood, as they assist them in planning for a healthy and productive AIDS-free life.

5.4 RECOMMENDATIONS

The results of this empirical study indicated that the adolescent-friendly HIV centre had a positive impact on adolescents in a number of ways: it provided them with relevant and accurate knowledge about HIV; it emphasised the importance of knowing their status, and encouraged them to be tested and treated; and it supporting them to live their lives and achieve their dreams, regardless of their HIV status. The following recommendations are based on the findings of this study and are relevant for clinical practice, nursing education, and further research.

5.4.1 Recommendations for adolescent-friendly clinical practice

- Health facilities must ensure that there is a dedicated space at the facility for adolescents to use to access health services, so that they do not have to mix with adults. This ensures privacy and confidentiality for adolescents.
- Comprehensive health services for adolescents need to be provided under one roof. This ensures their privacy and confidentiality, as their specific health issues will not be apparent, and they can avoid labels and stigmas. It also saves time, as they do not have to consult with multiple providers and join multiple queues.
- The patient flow must be clear at adolescent-friendly clinics, so that they know what to do from the time they enter the facility to the time they leave. This reduces anxiety and resistance, as they can confidently and easily move between different service points.
- The health services that are available at the adolescent-friendly clinic must be clearly displayed. This helps to alert adolescents to the services that are available for them, and avoids confusion about services that are not available.
- All service providers who serve the adolescents should be trained in adolescent friendly interpersonal communication to ensure that they demonstrate professional rather than personal values, and exhibit a friendly and non-judgemental attitude. This will encourage adolescents to make use of the services and they will feel comfortable to seek treatment for potentially embarrassing conditions (such as STIs or contraceptives).
- Adolescent-friendly clinics need to offer flexible operating hours and days to accommodate adolescents at school and adolescents who have jobs. Early morning hours, late afternoon/early evening hours, and weekend hours tend to be most convenient for adolescents. These extended hours also ensure shorter queues, which adolescents prefer for reasons of time and privacy.
- The philosophy of “nothing for youth without youth” should be applied to adolescent-friendly clinics. Adolescents should be engaged in the operations of the clinic to act as points of contact and as role models and mentors. Adolescent patients respond very positively to these youth ambassadors, who are able to mobilise them to make use of important services, particularly those that relate to HIV testing and treatment. As a bridge between adolescent patients and staff, and as young people themselves, youth ambassadors provide valuable insight into how

to implement services and programmes for adolescents in a way that is relevant, appropriate and effective.

- Health education in the form of group counselling should be facilitated for adolescents in adolescent-friendly facilities, as it helps them to gather accurate and relevant information, particularly on topics where multiple misconceptions exist in the community, such as HIV, sexuality, and pregnancy. Group settings save time, as a larger group of individuals can be addressed. One-on-one counselling can then be used more effectively to address specific or private questions and concerns. In addition, in a group setting, those who are more withdrawn benefit and gain knowledge from those who ask questions.
- Adolescents who are living with HIV and who are virally suppressed should be encouraged to share their success stories in order to reassure and motivate other adolescents to be tested for HIV, to start ART, and to promote adherence.
- It is absolutely vital for the service providers at adolescent-friendly clinics to always maintain ethical principles by ensuring the privacy and confidentiality of the adolescent patients, and to treat them with non-judgemental professionalism and respect.
- The establishment of peer-support groups should be scaled up at adolescent friendly clinics to allow adolescents who are living with HIV to receive psychosocial peer support. Through peer-support sessions, the coping strategies of those living with HIV can be shared, and this helps to empower adolescents to frame their HIV positive diagnosis more positively. They can then change their behaviours and develop the necessary life skills to live positive, productive and happy lives.

5.4.2 Recommendations for nursing education

- Schools, colleges, and universities that train health service providers should ensure that professional values are clearly understood and should emphasise that professional values should always take precedence over personal values, particularly in power relationships with young people. These institutions should also ensure that the ethical standards of the medical profession are clearly understood.

- Training institutions for psychologists and social workers should include in their curriculums the psychosocial support of both HIV-negative and HIV-positive adolescents.

5.5 SOME RECOMMENDATIONS FOR FUTURE RESEARCH

Since this study was confined to one specific site — the adolescent clinic of the Public Hospital in Maseru — it is recommended that a broader study of adolescent clinics at different hospitals and in different regions be conducted, in order to compare the emerging patterns adolescents' perceptions and experiences.

5.6 LIMITATIONS OF THE STUDY

This study was limited to the perceptions of nine adolescents who attended the adolescent clinic at Public Hospital in Maseru. Therefore, the findings cannot be generalised to other adolescent clinics, as the conditions may differ. Other aspects of this research were also limited. The size of the sample in this study was a limitation. The researcher stopped the interview process after interviewing nine participants as the data appeared to be repetitive, thus indicating data saturation. The results of this study cannot therefore be generalised to all adolescents. This is because other adolescents may have different perceptions on HIV-friendly health services. Only the nine adolescents who agreed to be interviewed were included. The perceptions of those adolescents who declined to participate may have offered alterative perspectives.

5.7 CONCLUSION

The problem of adolescents not accessing Lesotho's health services has been an issue with serious implications. AIDS is a leading cause of death and morbidity among Basotho adolescents, and appropriate health care interventions for adolescents and young people are key to ending the HIV epidemic in Lesotho. The youth are an important group, but they are often underserved in clinics and are given insufficient priority as a result of barriers unique to young people at their stage in life.

Lesotho's Ministry of Health has established adolescent corners to improve access for adolescents to health services. The Public adolescent health clinic was one of a number of the adolescent clinics established to address the issues that deter adolescents from accessing health services, but adolescents were not using it in large numbers, as was hoped. As a result, understanding the perceptions of adolescents about this centre was very important.

The adolescents in this study who visited the health centre reported quite a number of positive aspects that encouraged them to utilise the HIV services at the centre. They explained the factors that encouraged them to be tested, and to commit to HIV management and treatment. They described the support services for adolescents after they had tested HIV positive, in order to help them to cope with the situation, and also the support services for those who tested HIV negative, to help them remain negative.

The following overall conclusions can be drawn from the findings of the study:

- There must be increased Identification of HIV-positive adolescents and young people through intensified case finding.
- There is a need for enhanced linkage, adherence, and retention support for adolescents and young people living with HIV, and enhanced referral to preventive services.
- The physical, psychosocial, and economic barriers that harm the health of adolescents and young people need to be addressed.
- Meaningful involvement of adolescents and young people in the design and delivery of health services for these populations is highly beneficial to the success of these services.
- Operating hours and days at the adolescent-friendly clinics need to be flexible.
- It is vital that service providers at adolescent-friendly clinics be trained to adopt and adolescent-friendly attitude characterised by friendly, non-judgemental professionalism and respect.
- It is equally vital that the privacy, confidentiality, and anonymity of the adolescent patients be respected and taken into account in operational aspects of the clinic.

- Peer-support groups and group counselling sessions motivate adolescents to test for HIV, and to commit to HIV management and treatment, by providing psychological support, peer support, and a positive framing of the disease.
- Psychosocial support for adolescents promotes their adherence to ART.

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ANNEXURES

ANNEXURE A: PARTICIPANT CONSENT FORM

CONSENT TO PARTICIPATE IN THIS STUDY

I, _____ (participant name), confirm that the person asking my consent to take part in this research has told me about the nature, procedure, potential benefits and anticipated inconvenience of participation.

I have read (or had explained to me) and understood the study as explained in the information sheet.

I have had sufficient opportunity to ask questions and am prepared to participate in the study.

I understand that my participation is voluntary and that I am free to withdraw at any time without penalty (if applicable).

I am aware that the findings of this study will be processed into a research report, journal publications and/or conference proceedings, but that my participation will be kept confidential unless otherwise specified.

I have received a signed copy of the informed consent agreement.

Participant Name & Surname…… (please print)

Participant Signature……..Date……

Researcher's Name & Surname: RICHMOND TAGOE

Researcher's signature……..Date……

ANNEXURE B: CONFIDENTIALITY AGREEMENT

Title of Research: **Perceptions of adolescents on the use of HIV youth friendly centre at Maseru Lesotho**

Researcher: Thabiso Alphonce Lekhotsa

Student Number: 49992856

As a student researcher I understand that I may have access to confidential information about study sites and participants. By signing this statement, I am indicating my understanding of my responsibilities to maintain confidentiality and agree to the following:

- I understand that names and any other identifying information about study sites and participants are completely confidential.
- I understand that all information about study sites or participants obtained or accessed by me in the course of my work is confidential. I agree not to divulge or otherwise make known any of this information, unless specifically authorized to do so by approved protocol or by the local authority acting in response to applicable law or court order, or public health or clinical need.
- I understand that I am not to ask the participants questions for my own personal information but only to the extent and for the purpose of performing my assigned duties on this research project.
- I agree to report immediately should I become aware of an actual breach of confidentiality or a situation which could potentially result in a breach, whether this be on my part or on the part of another person.

12/09/2017_ Thabiso Alphonce lekhotsa

_____

Signature Date Printed name

12/09/2017 Thabiso Alphonce lekhotsa

_____

Signature of investigator Date Printed name

ANNEXURE C PARTICIPANT INFORMATION SHEET

28/07/2019

Title: Perceptions of adolescents on the use of HIV youth friendly centre at Maseru Lesotho.

Dear Prospective Participant

My name is **Thabiso Alphonce Lekhotsa** and I am doing research with Prof Thuledi Makua, in the Department of health studies towards a MPH at the University of South Africa. You are invited to participate in a study entitled**: Perceptions of adolescents on the use of HIV youth friendly centre at Maseru Lesotho.**

WHAT IS THE PURPOSE OF THE STUDY?

The purpose of this study was to investigate the perceptions of adolescents on the use of the HIV youth-friendly centre in a hospital in Lesotho.

WHY AM I BEING INVITED TO PARTICIPATE?

I purposefully choose you according to ethical considerations, and as the person who is assumed to be having the information relevant to the objectives of this study.

WHAT IS THE NATURE OF MY PARTICIPATION IN THIS STUDY?

You are a partner with whom the researcher will share the results of this study. You could have knowledge about the subject and it can benefit you with the information of the study to improve your well-being. The interview will not last longer than 45 minutes.

CAN I WITHDRAW FROM THIS STUDY EVEN AFTER HAVING AGREED TO PARTICIPATE?

Participating in this study is voluntary and there is no penalty or loss of benefit for non-participation and you are under no obligation to consent to participate. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a written consent form. You are free to withdraw at any time and without giving a reason.

WHAT ARE THE POTENTIAL BENEFITS OF TAKING PART IN THIS STUDY?

Your presence will be important for integration, and to give you the opportunity of selfdetermination, and it will benefit the society, by investigating about this topic. On the other side, your absence will not allow the researcher to know about your feelings of the concerning the topic.

ARE THERE ANY NEGATIVE CONSEQUENCES FOR ME IF I PARTICIPATE IN THE RESEARCH PROJECT?

Potential risk of participation can occur when the participant can feel discomfort about emotional, physiological, social or economic in nature. If there is any discomfort during the study, the researcher will refer you to the nearest health facility where you can access relevant health care.

WILL THE INFORMATION THAT I CONVEY TO THE RESEARCHER AND MY IDENTITY BE KEPT CONFIDENTIAL?

Your privacy will be ensured to protect information such as beliefs, attitudes, opinion of the participant, and not sharing the information with others without the contentment of the participant.

You have the right to insist that your name will not be recorded anywhere and that no one, apart from the researcher will know about your involvement in this research OR your name will not be recorded anywhere, and no one will be able to connect you to the answers you give. Your answers will be given a code number, or a pseudonym and you will be referred to in this way in the data, any publications, or other research reporting methods such as conference proceedings.

Your answers may be reviewed by people responsible for making sure that research is done properly, including the transcriber, external coder. Otherwise, records that identify you will be available only to people working on the study, unless you give permission for other people to see the records.

Anonymous data will be kept for your right of beneficence and respect your dignity and fidelity. In some case, this data may be used for research report, journal articles, and conference proceedings. Please keep in mind that it is sometimes impossible to make an absolute guarantee of confidentiality or anonymity.

HOW WILL THE RESEARCHER(S) PROTECT THE SECURITY OF DATA?

The audio tapes of your answers will be stored by the researcher for a period of five years in a locked cupboard/filing cabinet for future research or academic purposes; electronic information will be stored on a password protected computer. Future use of the stored data will be subject to further Research Ethics Review and approval if applicable. The electronic copies will be permanently deleted from the hard drive of the computer through the use of a relevant software programme.

WILL I RECEIVE PAYMENT OR ANY INCENTIVES FOR PARTICIPATING IN THIS STUDY?

There is no payment for this participation, but the reward is the opportunity that is given to you to discover about this topic, that can be benefit to you.

HAS THE STUDY RECEIVED ETHICS APPROVAL

This study has received written approval from the **University of South Africa, Department of Health Studies, Research Ethics Committee**. A copy of the approval letter can be obtained from the researcher if you so wish.

HOW WILL I BE INFORMED OF THE FINDINGS/RESULTS OF THE RESEARCH?

If you would like to be informed of the final research findings, please contact **Thabiso Alphonce Lekhotsa** (+266 58040930).

Should you require any further information or want to contact the researcher about any aspect of this study, please contact **Thabiso Alphonce Lekhotsa** 49992856@mylife.unisa.ac.za, and +266 58040930.

Should you have concerns about the way in which the research has been conducted, you may contact my supervisor and the **Chair of the University of South Africa, Department of Health Studies, Research Ethics Committee** can be accessed through the following details:

Supervisor: Prof Thuledi Makua

Tel: +2712 429 6754

Email: makuatp@unisa.ac.za

Chair of the University of South Africa, Department of Health Studies, Research Ethics Committee: Prof J J Mthibe-Neke,

Tel: +2712 429 6534

Email: mathijm@unisa.ac.za.

Thank you for taking time to read this information sheet and for participating in this study.

Thank you.

Thabiso Alphonce Lekhotsa

ANNEXURE D REQUEST FOR PERMISSION

Dear Sir/Madame

I, **Thabiso Alphonce Lekhotsa** am doing research with Prof Thuledi Makua, in the Department of Health towards a MPH at the University of South Africa.

The purpose of this study is to investigate the **Perceptions of adolescents on the use of HIV youth friendly services at Maseru Lesotho.**

The findings will give guidance to the health promoters authorities to plan and address the identified gaps and provide the necessary interventions. The study will also form baseline information for researchers and program planners.

Feedback procedure will entail the participation, the collaboration, the understanding, the partnership with every person in the institution.

Should you have concerns about the way in which the research has been conducted, you may contact:

Supervisor: Prof T. Makua,

Tel: +2712 429 6754 email,

*makuatp@unisa.ac.za***.**

Chair of the University of South Africa, Department of Health Studies, Research Ethics Committee: Prof J Mthibe-Neke,

Tel: +2712 429 6534

Email: mathijm@unisa.ac.za.

Thank you for taking time to read this information sheet and for participating in this study.

Thank you.

Yours sincerely

Thabiso Alphonce Lekhotsa

ANNEXURE

E DECLARATION

SECTION C
DECLARATION

CANDIDATE'S AGREEMENT TO COMPLY WITH THE ETHICAL PRINCIPLES SET OUT IN UNISA POLICY ON RESEARCH ETHICS

(1) Student agreement

I THABISO LECHOTA student number 47912856 have accessed, and have read, the Unisa Policy on Research at

http://cm.unisa.ac.za/contents/departments/res_policies/docs/ResearchEthicsPolicy_apprv Counc_21Sept07.pdf

Yes: [x] No: [ ]

I further declare that this form is a true and accurate reflection of the methodology I intend to apply, and that I have carefully contemplated possible ethical implications of the research methodology and domain specific and associated ethical issues and that I have reported on all of these.

I shall carry out the study in strict accordance with the approved proposal and the ethics policy of UNISA. I shall maintain the confidentiality of all data collected from or about the research, and maintain security procedures for the protection of privacy and anonymity. I shall record the way in which the ethical guidelines as suggested in the proposal, has been implemented in my research.

I shall work in close collaboration with my supervisor(s) and shall notify my supervisor(s) in writing immediately if any change to the study is proposed. I undertake to immediately notify the **University of South Africa, Department of Health Studies, Research Ethics Committee** in writing if participants sustain any adverse effect or injury or harm attributable to their participation in the study.
I also declare that the collected data will be used solely for the purpose of this study.

Signature 25/07/2017 Date

(2) Approved by Supervisor:

I, Dr Tshedi Mamiala acknowledged that I have checked that this form is complete, and that I approved the submission of the proposal for ethical clearance.

Signature 25/07/2017 Date

Open Public

ANNEXURE

F ETHICAL CERTIFICATE

UNISA university of south africa

RESEARCH ETHICS COMMITTEE: DEPARTMENT OF HEALTH STUDIES

REC-012714-039 (NHERC)

1 November 2017

HSHDC/762/2017
Mr Thabiso Alphonce Lekhotsa
Student No 49992856
Supervisor: -Dr T Makua
Qualification: D Litt et phil
Joint Supervisor: -

Dear Mr Thabiso Alphonce Lekhotsa

Decision: Ethics Approval

Name: Mr Thabiso Alphonce Lekhotsa

Proposal Perceptions of adolescents on the use of HIV youth friendly centre at Maseru, Lesotho

Qualification: **MPCHS94**

Thank you for the application for research ethics approval from the Research Ethics Committee: Department of Health Studies, for the above mentioned research. Final approval is granted from 1 November 2017 to 1 November 2019.

The application was reviewed in compliance with the Unisa Policy on Research Ethics by the Research Ethics Committee: Department of Health Studies on 2 August 2017.

The proposed research may now commence with the proviso that:

1) *The researcher/s will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.*

2) *Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study, as well as changes in the methodology, should be communicated in writing to the Research Ethics Review Committee, Department of Health Studies. An amended application could be requested if there are substantial changes from the existing proposal, especially if those changes affect any of the study-related risks for the research participants.*

University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
www.unisa.ac.za

ANNEXURE

G GRAND TOUR

Perceptions of adolescents on the use of HIV youth friendly centre at Maseru Lesotho.

Name of student: Thabiso Alphonce Lekhotsa Student Number: 49992856

One grand tour question will be used to investigate the **Perceptions of adolescents on the use of HIV youth friendly centre at Maseru Lesotho**. The grand tour question that the adolescents will be asked entails: what is the importance of the adolescent friendly HIV services to adolescents at Maseru Lesotho? Follow up questions will be used dependent on the participant's responses and in line with the objectives. Some of the questions to be covered will be as follows:

What challenges do you experience at the HIV youth friendly centre?

Why most adolescents do not use the HIV youth friendly centre?

ANNEXURE H TURNITIN REPORT

Final Dissertation for Examination

by Thabiso Lekhotsa

Submission date: 04-Jun-2020 06:38PM (UTC+0200)
Submission ID: 1337761964
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